Mayor's Office
CITY OF DETROIT

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October 14, 2019

VIA E-MAIL ONLY

Re: Joint Response to OIG Draft Findings, Case No. 19-0013-INV

Dear Ms. Ha,

I am legal counsel to Mayor Mike Duggan, Alexis Wiley, Ryan Friedrichs, and Sirene Abou-Chakra in relation to OIG investigation No. 19-0013-INV. Attached please find a joint written response to the Office of the Inspector General's draft report in that matter.

This written response is being submitted, on behalf of all four of my clients, in lieu of a hearing.

Should you have any questions, please do not hesitate to reach out.

Sincerely,

Senior Counsel to the Mayor
Special Assistant Corporation Counsel, City of Detroit

On behalf of:
Mayor Mike Duggan
Alexis Wiley
Ryan Friedrichs
Sirene Abou-Chakra

Cc: Mayor Mike Duggan
Alexis Wiley
Ryan Friedrichs
Sirene Abou-Chakra
Jennifer Bentley
Kamau Marable

Response to OIG Draft Findings, Case No. 19-0013-INV

This letter serves as the joint response, on behalf of Mayor Duggan, Alexis Wiley, Ryan Friedrichs, and Sirene Abou-Chakra, to the OIG's draft findings in case number 19-0013 INV. The draft report concludes, among other things, that (1) the Mayor provided "preferential treatment" to Make Your Date; (2) the City failed to follow its procurement processes with respect to Make Your Date; (3) Ms. Wiley made misleading statements to the media; and (4) Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra "abused their authority" in relation to a directive given to junior staff members to delete emails.

For the reasons outlined below, we respectfully request that all of those draft findings be revised and reversed. The draft findings are not supported by facts or applicable legal standards. The draft findings, moreover, threaten to impose severe, unwarranted damage to the reputation of several public servants—and further threaten to stymie effective governance in the City of Detroit.

Introduction

On April 5, 2019, the OIG opened an investigation that was very precise in scope: "whether the Mayor and/or any City officials potentially abused their authority by providing preferential treatment to the Make Your Date Non-Profit." That announcement followed an inaccurate media report suggesting that the Make Your Date non-profit was, in fact, the recipient of city funds and city resources. Mayor Duggan, the city administration, and Wayne State University (WSU) leadership were emphatic that Make Your Date was run exclusively as a university program, and that the similarly named non-profit had no involvement after it was placed in dormancy in mid-2014.

The OIG's original statement of investigation is as follows:

> **The City of Detroit Office of Inspector General (OIG) announces, as of Friday, April 5, 2019, that an investigation has been opened in regard to Mayor Mike Duggan and the City of Detroit's interactions with the Make Your Date Non-Profit. The OIG is duty-bound, pursuant to the Charter of the City of Detroit, to initiate and to pursue the investigation. In accordance with the Charter, the investigation will focus on whether the Mayor and/or any City officials potentially abused their authority by providing preferential treatment to the Make Your Date Non-Profit. Upon conclusion of the investigation, results will be shared with the Mayor's Office, City Council, and the public.**

The answer to the question posed in the statement of investigation—"whether the Mayor and/or any City officials potentially abused their authority by providing preferential treatment to the Make Your Date Non-Profit"—should be a simple and unqualified "no." There is absolutely no evidence that the Make Your Date *non-profit* ever received any funds or assistance from the City of Detroit. The draft report does not address this central question. And the answer to that question is essential to determining whether the Mayor or any other City officials engaged in "preferential treatment." Under generally accepted legal standards, it is impossible to determine

if a party received "preferential treatment" over other "similarly situated" parties without first defining that party's identity.

The straightforward conclusion that the Make Your Date non-profit received no City assistance was only buttressed this week by a finding from the Michigan Attorney General (AG). The same media story that triggered the OIG's investigation also triggered a parallel inquiry from the Michigan AG. The AG inquiry focused on the Make Your Date non-profit's reporting. Since its inception, the non-profit has always claimed the statutory exemption for non-profits that do not solicit or receive funds in excess of $25,000. Following the media report which suggested it was the non-profit was running the program, the AG thoroughly reviewed the activities of the Make Your Date non-profit and of WSU.

This past week the AG issued its finding, ruling that the Make Your Date non-profit properly fell under the exemption it had claimed. The AG further granted the Make Your Date non-profit a 7 year waiver of annual reporting requirements. *See* AG Ruling, Attachment 1. In short, the AG found that the Make Your Date non-profit had never solicited or raised more than $25,000. The AG determination can only be read to conclude that the media reports suggesting that the non-profit (as opposed to Wayne State) had been raising and spending money for Make Your Date were, in fact, inaccurate. Given that the OIG's investigation specifically focused on potential "preferential treatment" for the "Make Your Date *Non-Profit*" (emphasis added), we respectfully request the OIG to make that same determination here.

The Draft Report is an exhaustive document covering a range of complex issues. Not surprisingly, the information gathered in some areas is incomplete. In other areas, the information has been misinterpreted, and reaches conclusions that are incorrect. That is fair enough: in any draft report dealing with issues as complex as these, there are bound to be some errors.

More troubling, however, are the standards the OIG applied to its findings. The Detroit City Charter provides the OIG authority "to detect and prevent waste, abuse, fraud, and corruption." Detroit City Charter 7.5-311. In its draft report, the OIG interprets that charge to grant it the authority to make such findings as "preferential treatment" and "abuse of authority." But in making those findings, the draft report nowhere refers to the established legal elements that define those terms.

The draft report's failure to define those standards has real-world consequences. A finding that a City official engaged in "preferential treatment" or "abuse of authority" carries a reputational stain that can linger throughout that official's career. It is unfair to tar City officials with such adverse findings when those findings are based on an indeterminate standard. And beyond the adverse effect on *existing* employees, use of an undefined standard threatens to chill governmental operations. If City employees fear that they might be publicly censured for failure to abide by some indeterminate standard, they may be hamstrung in performing their duties. It will, moreover, be difficult to attract talent to the City if prospective employees fear that any perceived misstep will result in public censure.

For all of these reasons, the standards applied in the OIG report should be based objectively, on legal precedent. And—especially when properly contextualized in well-defined legal standards—all nine findings are either legally or factually incorrect.

Each of those findings is discussed, in turn, below.

OIG Draft Findings 1-3: Mayor Duggan "provided preferential treatment to MYD"

The draft report first concludes that Mayor Duggan (1) "provided preferential treatment to MYD"; (2) "such treatment was not best practice or good governance"; and (3) "The selection of MYD to partner with the City of Detroit . . . lacked fairness, openness, and transparency." Draft Report at 2. Those findings are wholly without merit. The Mayor appropriately prioritized infant mortality as a priority for his administration. And—relying on his unique expertise in hospital and medical care—the Mayor partnered with WSU, a unique institution with unparalleled expertise and resources, to run a program that has delivered up to 37% reduction in preterm births.

In Detroit, 135 babies die, each year, during their first year of life. Triple that number are stillborn, or miscarry late in pregnancy. And the women and children of Detroit, particularly African American women and children, suffer these tragedies twice as often those in the rest of Michigan.

Mayor Duggan has made addressing this inequity a priority of his administration. He partnered with America's leader in the research and care of high-risk mothers in Wayne State University (WSU)—drawing on WSU's unique partnership with the National Institutes of Health (NIH). The result was extraordinary. Women who received services from WSU via the Make Your Date program experienced a reduction of up to 37% in preterm births.

Contrary to the draft report's conclusion, Mayor Duggan's decision to partner with WSU did not qualify as "preferential treatment" under any standard recognized by any legal authority. There is no comparable entity anywhere in Michigan—and likely not anywhere in America—that could have matched the resources of WSU and the NIH. Mayor Duggan's decision to partner with WSU was a long-overdue engagement with unique, evidence-based university resources to address the critical problem of infant mortality.

The OIG cannot fairly offer a conclusion that it is "more probable than not" that the Make Your Date program received "preferential treatment" over other programs, Draft Report at 2, unless the OIG (1) identifies some factual basis for its assumption that equal or better partners exist, and (2) concludes that the decision to partner with MYD was not supported by a "rational basis." The draft report, however, identifies no such equal or better program. And the reason is simple: no such program exists.

I. Contrary to the Draft Report, the Correct Legal Standard for "Preferential Treatment" Requires Identification of Someone "Similarly Situated" who was Treated in a Disparate Manner

Section 7.5-306 of the Detroit City Charter gives the OIG the authority to investigate whether city officials or agencies engaged in "waste, abuse, fraud, or corruption." The OIG Draft Report concludes, quickly and unequivocally, that Mayor Duggan did not engage in any of these activities. But instead of ending there, the report goes on to a lengthy analysis of whether the Mayor engaged in "preferential treatment," a standard not contemplated or defined in the charter.

The definition used by the OIG Draft Report is not drawn from any legal standard in Michigan or elsewhere, but from a dictionary definition from vocabulary.com: "giving an advantage to a preferred person or group over everyone else." Draft Report at 5. By that standard, virtually every decision made by a public official would be defined as "preferential treatment."

City attorneys, for example, are paid more than other classes of employees, including bus drivers, police officers, and firefighters. Under the vocabulary.com definition cited in the report, they are "a preferred person or group," "given an advantage over everyone else." Further, all city employees receive health care benefits that the general public does not. The vocabulary.com definition would thus label them as receiving preferential treatment over the general public. The City replaced the old sodium street light bulbs with new, energy-efficient LED lights. Under the vocabulary.com definition, LED light vendors were given preferential treatment.

In fact, if "preferential treatment" is defined as giving some people a benefit that others might like to have, nearly *every* public official can be found to have engaged in "preferential treatment." Under the vocabulary.com definition, administering a progressive income-tax system—in which wealthier people pay a higher tax rate on their income—is "preferential treatment." Similarly, setting a low speed limit on a particular residential street would be "preferential treatment," as residents of other neighborhoods may also enjoy a lower speed limit on their streets. Even something as fundamental as our criminal-justice system would be rife with "preferential treatment." After all, the criminal-justice system advantages those who are not convicted of crimes, and disadvantages (in the form of criminal penalties) those who have been convicted.

Simply put, distinguishing between different groups of people is an integral part of government. That is why courts generally defer to governmental distinctions between people, scrutinizing those decisions only if they reflect "prejudice against discrete and insular minorities." *United States v. Carolene Prod. Co.*, 304 U.S. 144, 153 n.4 (1938). And significantly, the draft report cites no legal authority in support of its vocabulary.com standard.

There is, however, a well-established body law that *does* define "preferential treatment." If the OIG has decided its jurisdiction extends to making determinations of preferential treatment, we respectfully suggest that the standard used in Michigan—and throughout the country—be used. The caselaw requires three elements for a party to have been deemed to have engaged in preferential treatment:[1]

- *First*, there must be a "similarly situated" entity that was treated differently. *Stokes v. Greektown Casino,* 2004 WL 1397589 at *3 (Mich. Ct. App. June 22, 2004). That "similarly situated" entity must be "*prima facie* identical in *all* relevant respects or directly comparable ... in *all* material respects." *United States v. Green*, 654 F3d 637, 651 (6th Cir. 2011) (emphasis added).

- *Second*, the "similarly situated" entity that was treated differently must be a real, specific entity, that was treated differently in real, specific ways. Speculation there may be "similarly situated" persons does not suffice. *Tucker v. City of Detroit,* 2000 WL 3353857, at *3 (Mich. Ct. App. Jan. 18, 2000).

- *Third*, absent any evidence that the differential treatment was motivated by bias against a "discrete and insular minority," *see Carolene Products*, 304 U.S. at 153 n. 4, there must be a demonstration that there was no rational basis for the difference in treatment. *Oberly v. Township of Dundee,* 2012 WL 4210457, (Mich. Ct. App. Sept. 20, 2012).

The OIG draft report suggests—without citation—that "a greater level of scrutiny" is warranted when the government provides "preferential treatment" to a private party. Draft Report at 17. In fact, just the opposite is true. In context after context, courts have deferred to policymakers in claims alleging governmental "preferential treatment." In *Oberly v. Township of Dundee*, the court rejected a claim that certain businesses received "preferential treatment" from a township. Along the way, the court noted the "general rule" that government action "that treats similarly situated groups disparately *is presumed valid* and will be sustained if it passes the rational basis standard of review. *Id.* at *2, *3 (quoting *Shepherd Montessori Ctr Milan v. Ann Arbor Charter Twp*, 486 Mich. 311, 318-19 (2010) (emphasis added)). Other courts, nationwide, have applied a similarly deferential standard of review, in similar contexts. *See Laurels of Bon Air, LLC v. Med. Facilities of Am. LIV Ltd. P'ship*, 51 Va. App. 583, 596–601 (2008) (refusing to strike down a legislative act as a special law, because the act was not "so narrow and so arbitrary" as to not withstand rational basis review, even though at the time of its enactment the act potentially benefited only a single party); *Delogu v. State*, 1998 ME 246, ¶ 10, 720 A.2d 1153, 1155–56 (upholding a city's decision to provide a corporation with tax dollars as part of an

[1] The precise legal formulation for what constitutes "preferential treatment" varies depending on the cause of action that is being asserted. The three elements outlined in this response are distilled from (1) generally applicable standards for when something can qualify as "preferential treatment" in the first instance; and (2) cases analyzing when government policies that distinguish among people run afoul of the law.

economic incentive program, where the "legislative finding of public purpose [was] given great weight.")

II. None of the Legal Elements for "Preferential Treatment" is Supported by the Draft Report

A. Element 1: There Were No "Similarly Situated" Entities to WSU

One of the most puzzling aspects of the Draft Report is its failure to make an express determination that WSU has been the sole operator of Make Your Date. For the purposes of determining whether "preferential treatment" was given, that issue is *the* threshold question. Again, "preferential treatment" requires a finding that there were "similarly situated" entities who received worse treatment. It is impossible to identify "similarly situated" entities without first identifying the party that received the advantage.

Throughout the draft report, the OIG refers to the Make Your Date program as if it were somehow its own legal entity, capable of contracting, receiving funds, and accepting benefits. That is just not true. Make Your Date is a set of services offered by WSU to pregnant women in Detroit. WSU offers education services to the patients at its clinic, offers group-care appointments from its medical practitioners, offers transvaginal ultrasounds to detect risk factors for preterm birth, and offers referrals to its research partners from the NIH who are co-located in WSU facilities. All of these WSU services together make up "Make Your Date" and they are offered to women who enroll in the program.

WSU pays its staff to provide Make Your Date services to those who enroll. As far as a legal structure, then, "Make Your Date" is a Wayne State program. It is legally no different than other programs offered by Wayne State—for example, the "English 2100, Introduction to Poetry" course WSU offers to undergraduates. But it would be absurd to say that "English 2100" received preferential treatment. The question is whether the legal entity providing the service—WSU—received preferential treatment.

Wayne State University is unquestionably the sole entity that received funding and other support from the City for Make Your Date. This has now effectively been confirmed by the AG report (Attachment 1), has been spelled out in detail by the General Counsel of WSU (Attachment 2), and is further spelled out in the affidavit of Dr. Robert J. Sokol, former Dean of the WSU School of Medicine (Attachment 3). The Make Your Date non-profit has been entirely dormant since mid-2014 and the draft report does not cite a single fact to suggest otherwise.

Wayne State University is one of the leading research universities in America, and hosts the National Institutes of Health Perinatology Research Center, the U.S. Government's central research institution. There is no "similarly situated" entity anywhere in America, let alone in Detroit, that could have provided comparable resources to pregnant moms.

The magnitude of the resources that WSU and its affiliated NIH research partners brought to Detroit's high risk mothers is described in the affidavit of Dr. Robert Sokol. Dr. Sokol

is the current Chairman and a 36-year member of Michigan's Maternal Child Medical Committee, the former Chair of WSU's OB/GYN Department, the former Dean of the WSU Medical School, and one of the nation's most distinguished physicians and researchers in high risk pregnancies. *See* Sokol Affidavit, Attachment 3, Paragraph 2. Based on his 36 years of experience leading the efforts to help pregnant mothers in Detroit, Dr. Sokol details his frustration with the lack of effective programs from the Detroit Health Department in reducing America's highest infant mortality rate:

> Throughout my time at WSU, there has been no greater source of personal pain than the tragically high maternal and infant mortality rate suffered by babies in the City of Detroit. From my arrival in Detroit 36 years ago, African American babies have died twice as often as Caucasian babies and Detroit babies have died twice as often as other babies in Michigan.
>
> Throughout the decades, the City of Detroit Health Department has been less than highly effective in implementing any public health strategy to close this gap in my opinion. At WSU, we had to partner with hospitals to develop public health strategies on our own because there was never an effective or properly-resourced Detroit Health Department effort to address this problem.

Sokol Affidavit paragraphs 12-13.

Dr. Sokol details the extraordinary resources WSU brought to the table with the NIH to help Detroit's pregnant moms in Make Your Date:

> Page 20 of the draft report reads: "Based on the OIG investigation, there are other agencies that could have provided similar services." ***The draft report does not identify who these other agencies might be, but I can state with certainty that statement is completely false***. That statement reflects a lack of medical understanding on the services provided by Make Your Date. WSU's ownership of Make Your Date provided three major resources that could not have been provided by any other agency in Michigan, and likely not anywhere else in America:
>
> > a. WSU has a large OB/GYN Medical Department and affiliated practice, with about 40 faculty physicians, 40 residents, and 10 midwives. They provide medical care to Michigan's largest patient base of African-American, low-income, and high-risk pregnant mothers. The patients are nearly all seen at WSU-affiliated centers – either at the University Health Center Clinic at Hutzel Hospital or at the PRB research center at Hutzel Hospital. That means approximately 2,000 at-risk mothers came through one location each year to be seen by WSU medical staff, providing the opportunity for WSU Make Your Date staff to run pregnancy education programs for patients along with their pre-scheduled medical or research visits. Historically in Detroit, well-meaning patient education campaigns to reduce infant mortality have failed because they have only been able to reach small groups of women in small community

settings. WSU created a breadth of educational outreach in Make Your Date that I never have seen in Michigan, by coordinating with the medical and research visits to the WSU physicians and by helping ensure access to care with provision of transportation and other support.

b. A key component of Make Your Date is access to "group appointments", where a group of pregnant moms meet with their doctor/midwife together, instead of the traditional one-on-one appointments. WSU has been part of national research led by Yale University that has found major reductions in pre-term births when patients form bonds in group sessions. The WSU Ob/Gyn Department created a group-care practice run by its midwives so that pregnant moms would have this option. Make Your Date staff educated pregnant mothers on the WSU group-care option, made referrals directly into the program, and scheduled the patients' appointments. Only a major health care practice like the WSU Ob/Gyn group could have created such care options – no non-profit I am aware of has that capacity.

c. Pregnant moms who are treated by WSU medical staff are each given the opportunity to be referred to the NIH PRB research center at Hutzel Hospital for the term of their pregnancy. At the PRB, the world's most advanced medical researchers and can provide additional support for very high risk pregnancy conditions, which is extremely valuable for women who previously experienced growth-restricted pregnancies, miscarriages, or fetal deaths. The PRB site provides more frequent patient interaction, particularly after 24 weeks, watching for early signs of pregnancy complications. The increased surveillance and diagnostics from the PRB staff often provide early warnings of developing problems and lead to immediate referral to the emergency room or the patient's physician treating for pregnancy-saving interventions. The NIH's PRB is located in only one place in America – at WSU at Hutzel Hospital. There is literally nowhere else in the U.S., let alone in Detroit, that a high-risk mother can get access to their advanced pregnancy surveillance and diagnostics. WSU's Make Your Date coordinates referral of pregnant moms to WSU researchers at the PRB center.

The draft OIG report gives the impression that $350,000 in grant funding to Make Your Date was the essence of the services. Nothing could be further from the truth. A $350,000 grant by itself wouldn't even pay for a doctor and a nurse for a year. Make Your Date has been successful only because of the enormous resources of WSU, backed up by the NIH's national research. WSU made these resources available to thousands of Make Your Date clients in addition to the small grant contribution from the city.

Id. paragraphs 19-20 (emphasis added).

In summary, the legal requirement that "similarly situated" entities must be identified as a precondition for a "preferential treatment" finding is completely lacking in the draft report. Such a conclusion would require identification of another entity that:

- Has a 90-person practice group;
- Serves 2,000 patients at one site;
- Is physically located in Detroit;
- Has medical providers who are scheduling group care appointments, and whose doctors are affiliated with the NIH, and can refer their patients for advanced research and care.

As the Mayor clearly articulated in his interview, and as Dr. Sokol articulates in his affidavit, there simply is no "similarly situated" institution with the resources to help high risk pregnant mothers other than WSU, and its partnership with NIH.

B. Element 2: No Actual "Similarly Situated" Entity was Treated Differently, and the Draft Report Identifies No Specific Ways in which the Treatment was Disparate.

In claims sounding in "preferential treatment," Michigan courts have expressly stated that speculation there *may* be "similarly situated" persons does not suffice. *See Tucker v. City of Detroit,* 2000 WL 33538527, at *3 (Mich. Ct. App. Jan. 18, 2000) (denying claim sounding in race-based "preferential treatment" because, "[w]hile plaintiff asserts that other individuals were given preferential treatment and had their ideas adopted based on race," the plaintiff "fails to name *specific* individuals and identify their skin color and fails to identify *specific* plans which were received over the plans of individuals who were not given preferential treatment due to skin color.") (emphasis added). And to qualify as "similarly situated," one must be "*prima facie* identical in *all* relevant respects or directly comparable ... in *all* material respects." *United States v. Green,* 654 F3d 637, 651 (6th Cir. 2011) (emphasis added). In *Pletos v. Lake in Woods Homeowners Ass'n,* 2015 WL 1650803, (Mich. Ct. App. Apr. 14, 2015), for example, the court rejected plaintiffs' allegation that they had been treated "differently than other members" of a homeowners association that had received a more favorable payment plan for late assessments. The court noted that the plaintiffs failed to identify any other homeowners who were truly "similarly situated," because they had not identified any better-treated homeowners who, like them, were "delinquent since 2005" and "refus[ed] to pay regardless of . . . waivers of late charges." *Id*. at *19.

So what specific similarly situated entity did the draft report cite that was treated in a disparate manner from Wayne State? There are only two references, neither of which purport to identify who that similarly situated entity might be:

> **"There may have been additional programs [the Mayor] did not have knowledge of…."** Draft Report at 16.

> **"Based on the OIG investigation, there are other agencies that could have provided similar services…."** Draft Report at 20.

The draft report, however, is unable to identify any such agency, because none exists. This is exactly the kind of speculation the Michigan Court of Appeals has rejected as being insufficient to prove preferential treatment. *Tucker,* 2000 WL 33538527, at *3. Given the inability to identify a "specific" entity that was similarly situated to WSU, there should have been an unequivocal conclusion that no evidence of preferential treatment exists.

The actual experience of the Local Maternal Child Health (LMCH) program also demonstrates that no "similarly situated" entity exists. During Mayor Duggan's administration, the LMCH program spent $10,500,000. Of that, WSU received only $350,000, or 3% of the total funding. 97% was available to fund other infant mortality reduction initiatives. *See* LMCH Funding Summary, Attachment 4.

There is no specific similarly situated entity that was ever excluded from LMCH funding. WSU was only one of 19 agencies that received LMCH grants. It wasn't even the largest recipient – the Michigan Community Dental Clinic's pediatric dental program received nearly $600,000 in LMCH grants during this period.

By September 2017, WSU had decided the small amount of LMCH funding wasn't worth the amount of time spent dealing with government bureaucracy and declined to accept any more LMCH funds (which the draft report notes at page 6). So, for the last two years, there has been no LMCH funding going to WSU. LMCH is a very well-known source of grants in the maternal and child health agency community. Ninety-seven percent of the LMCH funds were available for other programs through 2017, and 100% of the funds have been available for other programs since. If, in fact, there were other agencies that could have provided similar services, why didn't they appear in the last 2 years?

The reason is again provided by Dr. Sokol:

> I have reviewed the draft opinion of the OIG, particularly pages 15-26 in which it is suggested that the City of Detroit gave "preferential treatment" to the Make Your Date program for not giving adequate consideration to other possible providers who could do the same thing. I can tell you from a medical and scientific perspective, that conclusion is completely false. For 36 years I have seen every single initiative in Michigan to reduce preterm birth and infant mortality.

Sokol Affidavit, paragraph 4.

The draft report fails to demonstrate the required element of identifying a single *specific* similarly situated entity that was *specifically* treated disparately. Under Michigan law, then, a finding of "preferential treatment" is not supportable.

C. Element 3: The Draft Report Fails to Demonstrate that the Mayor Lacked Rational Basis for Prioritizing the Reduction of Infant Deaths as a City Priority, or for Partnering with WSU to Help in Those Efforts.

In an apparent attempt to bolster its conclusion of "preferential treatment," the draft report highlights the amount of resources the administration put into infant mortality reduction compared to other priorities. The draft report cites the administration's efforts to raise philanthropic funds for Municipal ID cards, an industrial sewing center, a Goal Detroit Youth Soccer League, and training for staff running summer recreation centers. Draft Report at 12.

The draft report then criticizes the Mayor for prioritizing infant mortality reduction over other priorities:

> Additionally, the OIG investigation revealed that MYD received an inordinate amount of time and resources, considering the fundraising goal and scope of work when compared against other projects of similar size and scope.

Draft Report at 13.

The suggestion that elected officials must dedicate equal time and equal resources to "projects of similar size and scope" is unmoored from any plausible understanding of what government officials do. Elected officials, charged with overseeing a massive government enterprise, must inevitably prioritize certain agenda items over others. It was not, for example, "preferential treatment" for President Obama to prioritize passage of the Affordable Care Act during his first term in office over comprehensive immigration reform. Nor was it "preferential treatment" for President Eisenhower to dedicate "an inordinate amount of time and resources" to the interstate highway system—instead of, say, channeling those resources into America's fledging space program. Those are the policy judgments that government officials are elected to make. If officials' policy priorities are misguided, they should be held to account at the ballot box, not in an inspector general's report. *See Vance v. Bradley*, 440 U.S. 93, 97 (1979) ("[A]bsent some reason to infer antipathy, even improvident decisions will eventually be rectified by the democratic process.").

All of this is why, when a policymaker like Mayor Duggan prioritizes an issue, courts do not permit those decisions to be labeled "preferential treatment." Instead, the standard for review is whether that official had a "rational basis" for the decision. In *Oberly v. Township of Dundee*, 2012 WL 4210457, (Mich. Ct. App. Sept. 20, 2012), the court rejected a claim that certain businesses received "preferential treatment" from a township. In so doing, the court cited the "general rule" that government action "that treats similarly situated groups disparately *is presumed valid* and will be sustained if it passes the rational basis standard of review. 2012 WL 4210457, at *2, *3 (quoting *Shepherd Montessori Ctr Milan v. Ann Arbor Charter Twp*, 486 Mich. 311, 318-19 (2010) (emphasis added)). Similarly—in a case involving contracting by the City of Detroit—the court rejected a claim alleging preferential treatment by noting that "the City had a rational basis for terminating [the contractor's] bidding rights." *Fiore v. City of Detroit*, 2018 WL 5014196, at *7 (E.D. Mich. Oct. 16, 2018).

And the rational-basis standard is an extraordinarily deferential one. As the United States Supreme Court has explained, a law or policy subject to rational-basis review bears "a strong presumption of validity." *F.C.C. v. Beach Commc'ns, Inc*., 508 U.S. 307, 314 (1993). A policy will pass rational basis review "if there is *any* reasonably conceivable state of facts"—even those

"unsupported by evidence or empirical data"—that could provide a rational basis for the classification." *Id.* at 313, 315 (emphasis added). It does not matter what a policymaker's actual motivations were. Indeed, "it is entirely irrelevant . . . whether the conceived reason for the challenged distinction actually motivated" the policymaker. *Id.* at 315.

Of course, policymakers must ultimately defend their policy decisions, and the reasons behind them, to the electorate. But it is not the province of courts—or investigators—to scrutinize a legitimate prioritization of one program over another. Put starkly, under rational-basis review, the Mayor's prioritization of Make Your Date could be justified by nothing more than speculation that the Mayor did not like babies dying, and thought WSU could help.

But there is more—far more—to justify the Mayor's decision to prioritize infant mortality. Although Mayor Duggan had absolute discretion to prioritize the issues of his choosing, the issue he chose to prioritize was quite literally one of life and death. In his nine years as head of the Detroit Medical Center (DMC), Mayor Duggan spent a great deal of time in the Hutzel Neonatal Intensive Care Unit where premature babies spend weeks in incubators fighting for their lives—with breathing and feeding tubes placed down their mouths and noses just to try to keep them alive. The fact that African American babies in Detroit suffer these conditions at double the rates of babies in the suburbs is something the Mayor considers a tragic situation, which is of the highest priority. It is difficult to understand how the draft report can characterize it as "preferential treatment" for the Mayor to spend more "time and resources" to save those babies' lives than he did to raise money for a sewing center or a soccer league. *But see* Draft Report at 13.

Dr. Sokol documents the Mayor's long history in fighting for the best care for high-risk Detroit mothers and babies:

> In 2003, the Board of Directors of the Detroit Medical Center publicly announced its decision to close Hutzel Hospital because of huge financial losses, which would have created human tragedy for many of the 5,000 high risk moms and babies treated at the hospital each year. By the time Mike Duggan was named as the CEO of DMC in 2014, the closing of Hutzel had already been accepted as a foregone conclusion. The new CEO shocked many of the long-time medical staff at Hutzel when he told them at the first meeting that he was going to do everything he could to get the DMC Board to reverse its decision and keep Hutzel open for the Detroit community. What he demanded from the doctors and employees at DMC was a much higher level of service every day, change he drove with metrics-driven, evidence based decision. We changed the performance of Hutzel Hospital and that institution still continues to serve the City of Detroit 16 years after its announced closure.

Sokol affidavit, paragraph 23.

Mayor Duggan's experience running Hutzel Hospital also justified his conclusion that WSU and its NIH partners could have a greater impact on reducing preterm birth than any other potential partner. Not only was that decision rational at the time, the scientific results from

WSU's efforts at reducing infant mortality are remarkable. Dr. Sokol describes the significant benefits Detroit moms have realized from the Make Your Date program:

> The success of WSU's extraordinary efforts in running the Make Your Date program have now been documented by the highly respected scientist, Dr. Adi Tarca, and his research team at Wayne State University. His research shows that for the approximately 2,000 women served in 2014 and 2015, Make Your Date mothers were 37% less likely to deliver at under 32 weeks than non-Make Your Date mothers at the same hospital. Make Your Date mothers were 28% less likely to deliver at under 34 weeks. As scientist who has worked in this field for decades, I can say without hesitation that these early results are remarkable. (Summary Attached) This confirms the previous efficacy trial (Article Attached) and demonstrates clinical effectiveness – it is a massive, truly remarkable decrease in a major perinatal adverse outcome.

Sokol Affidavit, paragraph 22.

Under any conceivable standard, the Mayor's decision to prioritize infant mortality—and to partner with WSU to do so—easily meets (and well exceeds) the rational basis standard.

D. None of the Other Issues Cited in the Draft Report Justify a "Preferential Treatment" Finding

a. Emails by Some DHD Staff Showing Resistance to the Mayor's Strong Commitment to the Evidence-Based strategies of Make Your Date do not Suggest "Preferential Treatment"

The draft report cites extensive evidence that DHD staff did not agree with Mayor Duggan's insistence that the Health Department support WSU's evidence-based program to reduce preterm birth and infant mortality. Legally, that evidence is entirely irrelevant. City employees may not like the direction charted by their leaders. But that hardly makes that direction lacking in rational basis.

By way of example: A review of emails from the police department will almost certainly show objections to the Mayor's insistence on 100% deployment of body cameras on police officers. Many in the Fire Department objected to the Mayor's initiative to train all 800 firefighters as medical first responders. Detroit Department of Transportation bus drivers were resistant to the GPS monitoring of buses and measurement of each driver's on-time performance. Members of the Public Lighting Department resisted the Mayor's decision to abandon old sodium lights and move to energy efficient LED street lights. None of this, of course, demonstrates that any of these decisions lacked rational basis, or that they constituted "preferential treatment."

By the same token, grumbling by DHD staff as to the Mayor's decision to support WSU's Make Your Date program does not demonstrate "preferential treatment." Instead, the emails show a Mayor who was, against institutional backlash, seeking to better DHD's performance in a city with the highest infant mortality rate in America.

Again, lest there be any doubt as to the "rationality" of the program, Dr. Sokol is insightful:

> It is extremely unusual to have a Mayor who is himself highly knowledgeable in the science and practice of delivering care to high-risk mothers. I read with interest the complaints from city employees about Mayor Duggan's efforts to fundamentally change the city's practices in providing care to pregnant moms. It is a reaction familiar to many who were at DMC when he first arrived and started demanding higher levels of performance from everyone. For decades, the City of Detroit's infant mortality rate has not only been among the highest in America, our babies die at rates higher than many third world countries. You would hope that employees at the Detroit Health Department would be embarrassed at that record and would embrace evidence-based change. You would hope that employees in the grants department would consider raising funds to save babies' lives to be their highest calling and not a nuisance they were being pressured to perform. But what I see is a Mayor of Detroit who has taken the initiative to finally demand that the City of Detroit respond to the infant mortality crisis with evidence-based medicine and strategies that have been proven to be effective. If I fault Mayor Duggan for anything, it is for not doing more to support Make Your Date. While Make Your Date has been extremely effective for those moms who got its services, fewer than 10% of Detroit's pregnant moms were enrolled. To make a meaningful impact on the overall infant mortality rate in Detroit, it is critical that Make Your Date be resourced sufficiently to be available to all pregnant mothers in the city.

Sokol Affidavit, paragraph 24.

Simply put, a Mayor demanding new, evidence-based strategies from city agencies is not preferential treatment. City agencies may not like change, and may be hesitant to embrace new programs. But, at the end of the day, City personnel work for the people's elected leader. It would be dangerous to the functioning of democratic government if employee reticence can be transmogrified into a legal basis for undermining mayoral priorities.

b. DHD Funding of Lyft Transportation for Pregnant Moms did not Benefit WSU

Perhaps no part of the draft report more unfairly maligns WSU than the suggestion that WSU benefited from DHD's funding of transportation services. *See* Draft Report at 2. Nothing could be further from the truth.

The Health Department leadership determined that low income pregnant moms were not getting prenatal care because they lacked access to convenient transportation for doctor visits. DHD made the determination that a contract with Lyft to pick the moms up at their homes and take them directly to the doctor would be the most cost-effective way get them critical care.

The only way to manage the transportation so that it was only used for pregnant moms, and only for the purpose of medical appointments, was to have the Lyft rides booked by staff who had the information to confirm the legitimacy of the request. DHD staff had the records of

Sister Friends enrollees and could book their appointments, but the number of Sister Friends enrollees was limited. Accordingly, to expand the number of pregnant moms getting this service, DHD asked WSU to provide the booking services for Make Your Date enrollees.

To suggest that WSU in any way benefited from that partnership is false. No money ever went to WSU. All payments went directly from DHD to Lyft. WSU committed its own staff to providing the booking service, free of charge. WSU would have surely been justified in asking for a DHD contract to pay for the WSU booking staff—particularly after the LMCH funding stopped in September, 2017 and WSU was receiving no city funding whatever for Make Your Date.

Instead, WSU supplied its own staff, at its own cost, to provide booking services so the Detroit Health Department could get more pregnant moms to their doctors. WSU donated its services to support the DHD Lyft initiative without compensation. It is completely inaccurate to suggest that WSU benefited from the Lyft program. The only people who benefited were Detroit's pregnant moms.

***

In short, when Mayor Duggan sought to address America's highest infant mortality rate by enlisting America's leading university in high-risk pregnancy research—a university, it bears emphasis, that was physically located in Detroit—it was not "preferential treatment" in any manner recognized by legal authority. Absent a showing of a specific entity similarly situated to WSU, and the showing of a lack of rational basis for Mayor Duggan, a finding of preferential treatment cannot be justified.

OIG Draft Finding 4: DHD violated city procurement policy in the LMCH contract with WSU

Next, the draft report concludes that DHD "violated City of Detroit procurement policies by awarding Local Maternal Child Health (LMCH) funding to MYD without a competitive bid process." Draft Report at 2. That finding is based on the mistaken assumption that the Make Your Date partnership was a city procurement. In fact, LMCH grants are a *state-driven* procurement whose contract management has been assigned to the Southeast Michigan Health Association (SEMHA). These unique, state-drive procedures have been signed off on by the Detroit City Council. And crucially, the procedures did not apply only to Make Your Date. Instead, the same processes—which DHD has scrupulously followed—applied to *all* LMCH procurement requirements for all 19 LMCH subcontractors over the last seven years.

The draft report overlooks all of that context, and instead faults DHD for failing to comply with "City of Detroit procurement policies" when awarding LMCH funding to MYD. Draft Report at 2. That conclusion, however, rests on the incorrect premise that the City of Detroit was the entity that contracted for these services. As the draft report says:

> OCP is responsible for managing the bid process and ensuring a fair, competitive, and value-driven environment in which to purchase government goods and

> services. The City of Detroit must competitively bid all new contracts to the greatest extent possible….However, this process was not followed when MYD was awarded LMCH funds.

Draft Report at 19.

The draft report's entire analysis regarding procurement thus starts with the faulty premise that the Make Your Date grant was a city procurement, governed by the OCP process. It was not. Local Maternal Child Health (LMCH) funds are federal funds administered by the State of Michigan Department of Health (MDH). The process by which the many LMCH subcontracts like WSU are awarded is governed by a strict state process. It is not a city contracting process and the city is not a party to the subcontracts. Instead (as the draft report itself notes) it was the Southeastern Michigan Health Association (SEMHA), not the city of Detroit, that entered into the contracts to fund WSU. Draft Report at 20.

The reason SEMHA entered into the contract with WSU is because the City has, for the past seven years, delegated to SEMHA the authority to perform grant subcontractor management for LMCH funds. That partnership began under Mayor Dave Bing, and continued under Emergency Manager Kevyn Orr and Mayor Duggan. And the contract for SEMHA to provide fiduciary fiscal management services for administration, and contract management for federal and state grant funds, applies not only to LMCH but to 10 separate city programs:

1. WIC Residential
2. WIC Breastfeeding
3. Infant Safe Sleep
4. Essential Local Public Health Immunization
5. Immunization IAP
6. Local Maternal and Child Health (LMCH)
7. Fetal Infant Mortality Review
8. Public Health Emergency Preparedness
9. Public Health Emergency Preparedness Cities Readiness Initiative
10. HIV Integrated Planning

SEMHA contract, Attachment 7.

The Detroit City Council has repeatedly reviewed and authorized the delegation of the contracting and management of state and federal grant funding to SEMHA, approving SEMHA's main master contract on October 7, 2014 and again on October 16, 2018. In addition, multiple SEMHA contract amendments have been approved by City Council over the last five years.

In short, DHD's process for handling LMCH subcontracts and SEMHA's role as master contractor has been well-known to state officials, Detroit City Council, and the public in general for the last 7 years. These subcontracts are not City procurements, but instead involve a very detailed 7-step procurement process involving state, city, and SEMHA reviews:

1) The State of Michigan Department of Health (MDH) annually adopts a series of "State Performance Measures" (SPMs) and offers LMCH grants to local health departments across Michigan to implement specific programs to address those SPM's in each jurisdiction. Attachment 5, page 6.

2) Detroit City Council each year reviews and approves the acceptance of the $1.7 million LMCH grant and its terms during the annual city budget process. Attachment 6.

3) Detroit City Council approves a master contract with SEMHA to provide contracting, management, and fiduciary services for the implementation of a wide range of state and federal grants, including LMCH. Since 2012, SEMHA has been the master contractor and the party that enters into all subcontracts for LMCH grants. SEMHA Contract, Attachment 7.

4) Based on the State Performance Measures determined by MDH, DHD staff develop a proposal to be submitted to MDH known as a "budget and plan" in which they list all proposed subcontractors for that year, the amounts of the subcontracts, and the services to be performed. Attachments 8A and 8B.

5) MDH independently reviews the local proposed "Budget and Plan," and determines whether to approve the proposed programs and each proposed subcontract. Although the draft report says that OCP was deficient in failing to perform RFPs for the subcontracts, MDH rules have no such requirement. And for good reason. The timing for completing all of the state and local LMCH steps each fiscal year in time to deliver programs is already very challenging. The requirement to add in RFP processes would likely mean the fiscal year would be nearly over by the time the process is complete. MDH has instead implemented a system where MDH independently reviews and approves each subcontract in its Budget and Plan approval process, to provide a second review of DHD program recommendations. MDH accepts, rejects, or asks for modifications of the budge and plan, including the subcontracts. MDH LMCH Contracting Rules, Attachment 9.

6) Once MDH is satisfied and formally approves the local Budget and Plan, it sends the local health department an agreement for the implementation of the plan. Agreement, Attachment 10.

7) Upon receipt of the Plan Agreement from MDH, SEMHA—to which the City of Detroit has delegated management of the LMCH Budget and Plan—enters into negotiations with subcontractors to perform the services approved by MDH.

WSU's contract for Make Your Date was one of 19 subcontracts SEMHA has entered into under this process over the last seven years. *See* SEMHA/WSU Contract, Attachment 11. The OIG Draft Report singles out only the LMCH funding to WSU for Make Your Date, giving the impression that the WSU contract process was somehow different from the others. It was not. Again, from 2014 through 2018, 19 different agencies have been awarded LMCH

subcontract grants, all of them under this same state-governed process. *See* LMCH Subcontractor Grant List, Attachment 4. And again, these processes were well-known to City and state officials.

In fact, the draft report cites only one person who (over the course of seven years) raised a question as to whether the LMCH procurement process was being properly followed. But even that exchange was seriously mischaracterized. The draft report notes:

> OCP policy dictates that it is best practice to competitively select services to ensure a fair, open, and transparent process. In fact, former Deputy Director of DHD Leseliey Welch expressed such concern in an email dated January 15, 2015.80 She stated "I am now wondering if there might be challenges with the $200,000 Make Your Date (MYD) contract, since it was allocated and not bid…"

Draft Report at 20.

The quote of that one sentence gives the impression that a leader at DHD, the Deputy Director of the Department, was concerned that something improper was going on. A review of the full email exchange, however, paints a completely different picture for three reasons:

1) Ms. Welch was not the deputy director of the Department when she wrote the email in January 2015. At the time of the email, she was a private contractor working for the Health Department and was writing to the acting Director Deborah Whiting to try to learn the LMCH contracting process.

2) In the full email, Ms. Welch starts by saying she had only looked at the SEMHA manual for the first time that evening and was trying to understand the detailed seven-step LMCH subcontracting process:

   > "Hi Deborah – I borrowed a copy of SEMHA Procurement Policy and Procedures form Patrick and had an opportunity to review it this evening.
   > I am now wondering if there might be challenges with the $200,000 Make Your Date (MYD) contract, since it was allocated and not bid…"

   Ms. Welch thus was not the Department's Deputy Director, expressing concern about a process she understood. She was a contractor asking a reasonable question about a process with which she wasn't familiar.

3) DHD's Acting Director, Ms. Whiting, responded quickly and definitively: ***"DHWP consultants do not have to be bid. Make your [Date] does not require bidding either, just as the Cincinnati model will not."*** Ms. Whiting thus understood the seven-step process and understood that the LMCH subcontracting rules did not require RFPs, but instead required independent state review and approval.

This email exchange does not show DHD leadership suggesting there were improper bid procedures. It shows a contract employee first learning how to use the seven-step process and

shows DHD Director Whiting explaining how the process worked. Director Whiting's response was correct—clearly showing that as far back as 2015, DHD leadership fully understood and followed the MDH procurement process.

Further confirming the diligence of DHD in following the correct LMCH procurement, the Michigan Auditor General specifically and exhaustively audited DHD's performance under the LMCH contract for the period 10/1/16-9/30/17. The Auditor General's report was released in June, 2018. Though the Auditor General found deficiencies in other aspects of the program, its conclusion regarding DHD's procurement performance was favorable:

PROCUREMENT STANDARDS

Objective 4: To assess the City of Detroit's effectiveness in complying with applicable procurement standards related to the Professional Services Contract with the Southeastern Michigan Health Association.

Conclusion: The City of Detroit generally complied with applicable procurement standards

State Auditor General Report, Attachment 12.

The only exception to the finding of compliance on procurement standards was a technical issue involving the original SEMHA master contract. There was no finding whatsoever of non-compliance in DHD's handling of the subcontracts. Importantly, the Auditor General's report covered 2016-2017, a year in which WSU was a subcontractor.

* * *

The WSU LMCH subcontract was one of 19 subcontracts handled by DHD in the last seven years. The procurement followed the same legal process as the other 18, and the State Auditor General found no evidence of noncompliance in the process. A finding that the city procurement process was violated by DHD for WSU would necessitate a finding that every single subcontract was in violation for the last seven years. They were not. DHD scrupulously followed the approved MDH/SEMHA contracting process.

OIG Draft Finding 5: Alexis Wiley made an incorrect media statement

The draft report next concludes that "ODG staff successfully assisted MYD in raising grant funds, in direct contradiction to the initial public statements made by the Mayor's Chief of Staff, Alexis Wiley." Draft Report at 2. As a preliminary matter, Ms. Wiley does not work for ODG, and is not involved in ODG's day-to-day work. All of her public statements were based on second-hand understanding of ODG's involvement with Make Your Date, following consultation with ODG employees.

More fundamentally, however, all of Ms. Wiley's public statements were entirely accurate.

The draft report does not specifically identify *which* "initial public statements" it believes are false, but the finding appears to be based on page 15 of the Draft Report:

> The Mayor's Office issued a press release on April 4, 2019. It stated that "no city funds were ever provided to Make Your Date non-profit and no private money was ever raised for it. Every dollar of city funds went directly to Wayne State University." Ms. Wiley also made this distinction in an April 2, 2019 email which stated, in part,
>
> > City staff briefly collaborated with the Wayne State philanthropy department to try to raise funds for the Wayne State program, but those efforts were unsuccessful and no funds were raised. At no time did anyone from the city participate in any fundraising effort for Make Your Date nonprofit- all efforts were a direct collaboration with university staff for the university-run program.
>
> However, this is a distinction without a purpose. Though City funds were paid to WSU, it was with the understanding that it would be used solely for MYD. This, in part, is evidenced by a Memorandum of Understanding (MOU) between DHD and WSU dated August 28, 2015. The MOU set forth the "understanding that each party desires to finalize contract negotiations for [DHD] to fund select program activities for WSU's Make Your Date program activities." Additionally, emails regarding ODG's fundraising efforts for MYD included not just WSU staff but also MYD staff. Therefore, though City of Detroit funds may have initially flowed to WSU, the money was undisputedly designated for MYD. Based on the evidence gathered by the OIG, to suggest otherwise would be simply inaccurate.
>
> Draft Report at 15.

Even by the draft report's own lights, Ms. Wiley's statement was entirely truthful. At the time Ms. Wiley made her statement to the media, she was responding to reporters who were erroneously suggesting that Dr. Sonia Hassan was running a non-profit that was in violation of state laws by illegally claiming a reporting exemption in its state tax filings. The reporters were claiming that it was the non-profit that was actually the entity soliciting, receiving, and spending funds to run the Make Your Date program—and that the City of Detroit was funding a non-profit that was in violation of state law in its public filings. In the public statement quoted in the draft report, *see id.,* Ms. Wiley correctly emphasized that the City had at no time funded or supported the activities of the non-profit. Instead, the City's contracts and all support were done entirely with WSU.

Ms. Wiley's position is unequivocally supported by WSU General Counsel Lou Lessem. *See* Attachment 2. Ms. Wiley's position was further vindicated by the recent AG ruling which concluded that the non-profit had properly claimed its exemption because it had not been soliciting or receiving funds.

The Draft Report includes numerous misstatements of fact on this issue:

1. **"Additionally, emails regarding ODG's fundraising efforts for MYD included not just WSU staff but also MYD staff." Draft Report page 15.**

This statement that emails were sent both to "WSU staff" and "MYD staff" is inaccurate—and, once again, the inaccuracy flows from the draft report's failure to expressly conclude that all Make Your Date functions were run by WSU. Simply put, there is no such thing as "Make Your Date staff" separate from WSU. All Make Your Date staff *are* full time WSU employees, receiving WSU paychecks, and with WSU email addresses. Make Your Date is simply the WSU program to which they are assigned. A simple review of the emails shows that all recipients have WSU email addresses.

The Attorney General report confirms Make Your Date had no staff of its own: **"It appears this organization does not compensate staff or independent contractors for services related to fundraising.**" AG Report, Attachment 1. The draft report gives no explanation as to how it reached the incorrect conclusion that there were any Make Your Date staff other than WSU employees.

2. **"Therefore, though City of Detroit funds may have initially flowed to WSU, the money was undisputedly designated for MYD." Draft Report at 15.**

The suggestion that the money "may have initially flowed to WSU" implies it was later sent on to someone else. It was not. It was used to pay the salaries of the WSU staff who ran Make Your Date, as the annual reports clearly show. The Draft Report's phrasing is another reflection of the erroneous premise that Make Your Date existed as an entity outside of WSU and somehow funds could flow from WSU to a separate entity. That is factually wrong. Ms. Wiley always acknowledged that the money and support were for the Make Your Date program. Her statement disputed only that it was the non-profit that was that received the funds. Her statement is thus entirely accurate.

3. **The claim that the difference between the non-profit and WSU is a "distinction without a purpose." Draft Report at 15.**

The draft report concludes that the distinction between WSU and the Make Your Date non-profit is "a distinction without a purpose." Draft Report at 15. In so doing, the draft report suggests Ms. Wiley was intentionally doing meaningless hairsplitting when she noted that "all efforts were a direct collaboration with university staff for the university-run program." *Id.* In fact, the difference the inert Make Your Date non-profit and the successful WSU program is enormous. When Dr. Sokol, the former Dean of the WSU Medical School and the former WSU site director the NIH research center, read the claim in the draft report that WSU and the non-profit were essentially interchangeable, he reacted emphatically:

> On page 15 of the draft OIG report, the difference between the nonprofit and WSU is called, "a distinction without a purpose". This is nonsense! The difference is profound. It is a comparison of the resources of a newly-formed nonprofit versus a University affiliated with the most renowned perinatal research center in the world. WSU is a $1 billion a year institution whose President, Roy Wilson, is a former NIH executive who has personally strongly backed WSU's Make Your Date program. The WSU School of Medicine has strongly supported Make Your Date's

> efforts through its medical staff. The NIH has committed $167 million in research funding on preventing infant mortality and preterm birth in its current contract with WSU to be done at the PRB center in Hutzel Hospital in Detroit. What WSU did with Make Your Date was to create the bridge for high-risk pregnant mothers in Detroit to access all those resources in a coordinated way. No non-profit can compare to that level of resource commitment – it is a huge distinction.

Sokol Affidavit, Paragraph 16.

The facts, the AG report, and all corroborating evidence show unequivocally that Ms. Wiley's statements were entirely accurate when she said "Every dollar of city funds went to Wayne State University" and "all efforts were a direct collaboration with university staff for the university-run program." There is thus no justification for a finding that she made a public misstatement.

OIG Draft Finding 6: Funding for the Lyft rides were allocated to benefit MYD "in direct contradiction to the initial statements made by Ms. Wiley."

The draft report next concludes that "City of Detroit general funds have been . . . allocated to MYD participants . . . in direct contradiction to the initial statements made by Ms. Wiley." This issue is discussed at length above. *See supra* Findings 1-3. Make Your Date is a set of services offered by WSU. "Make Your Date" is not a separate entity that can itself receive a "benefit." WSU is the party that is participating in the Lyft partnership by booking Detroit's pregnant moms to get to their doctor appointments.

As noted above, Ms. Wiley was absolutely correct that WSU received no benefit from Lyft. No Lyft funding ever went to WSU. No city funding ever paid for the WSU staff who did the bookings for the pregnant moms. The Lyft rides were a Detroit Health Department initiative to help the pregnant citizens of the City of Detroit get to their doctor appointments. It was *WSU* that provided a benefit to the Detroit Health Department by donating its staff resources to assist in Lyft bookings, with no compensation whatever from the City. WSU itself received no benefit.

Ms. Wiley's statement that the Lyft program did not benefit WSU—but only benefited pregnant women—was thus entirely accurate. There is no basis for a finding that she made a false statement.

OIG Drafts Finding 7-9: Alexis Wiley, Ryan Friedrichs, and Sirene Abou-Chakra "abused their authority" in ordering emails deleted.

Finally, the draft report concludes that three City of Detroit appointees "abused their authority" in relation to a directive, given to two junior Office of Development and Grants (ODG) employees, to delete emails regarding Make Your Date. *First,* the report concludes that Chief of Staff Alexis Wiley "abused her authority when she ordered" Monique Phillips and Claire Huttenlocher to delete Make Your Date emails. Draft Report at 29. *Second,* the report

concludes that Ryan Friedrichs and Sirene Abou-Chakra "also abused their authority by relaying the directive to Ms. Phillips and Ms. Huttenlocher." *Id.*

Even assuming the facts as found in the report, the email-deletion directive does not rise to the level of "abuse of authority." Tellingly, the draft report's conclusion is not supported by the citation of any legal standard for the elements of a finding of abuse of authority. A finding that a governmental official "abused authority" is one of the most serious conclusions that can be made, which is why the legal system has always reserved a finding of "abuse of authority" only for conduct that is extreme and inexcusable.

Under federal law, for example, "abuse of authority" is a cognizable constitutional claim only if it "shocks the conscience" and is an "egregious abuse of governmental power." *Shehee v. Luttrell*, 199 F.3d 295, 301 (6th Cir. 1999). Similarly, when reviewing decisions by administrative tribunals, courts have conceptualized "abuse of authority" as on par with decisions tainted by "fraud, collusion, or other unlawful means." *Kuykendall v. City of Grand Prairie*, 257 S.W.3d 515, 518 (Tex. App. 2008). And in the government employment context, state courts have held that "abuse of authority" is a "pattern of misconduct" consisting of "malicious and corrupt acts"—as opposed to "minor neglect of duties, administrative oversights and violations of law." *See Chandler v. Weir*, 817 N.Y.S.2d 194, 195 (App. Div. 3d 2006).

An "abuse of authority," then, is an extraordinarily severe charge which carries with it a serious reputational stain. It has always been held to be more than a lapse in judgment. An investigator or tribunal should thus lay out the specific elements that constitute an "abuse of authority" charge. And if an "abuse of authority" finding is reached, it should be accompanied by specific findings as to each of those elements.

The draft report places Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra in an impossible situation in preparing a response because the report nowhere defines the phrase "abuse of authority," and thus makes no express findings as to the elements of that charge. That shortcoming is not merely procedural. The conduct at issue in the draft report—a single "order" to delete emails—falls far short of any of the generally accepted definitions for what constitutes an "abuse of authority."

To be sure, the directive to delete the emails may have been an error in judgment. It may have fallen short of best practices regarding government transparency and openness. But the facts outlined in the report contain none of the traditional indicia of an "abuse of authority." The single, isolated order was not part of a pattern of misconduct (and indeed, the City issued an executive order soon after the deletion directive to ensure that all City emails are retained for at least two years). At the time the directive was given, moreover, there is no indication that Ms. Wiley, Mr. Friedrichs, or Ms. Abou-Chakra believed they were doing anything wrong. None of the three officials deleted any of their own emails, so they clearly were not motivated by a desire to obscure misconduct. And there is absolutely no indication that any of the three officials believed that the emails contained damaging information—and the emails contained no such information. Finally, and crucially, nobody suffered concrete harm as a result of the email deletions.

Simply put, there are no factual findings as to how the conduct at issue rises to the level of "abuse of authority. There is speculation and unsupported theories, but not a single fact that the deletion directive was inspired by malignant motives. Yet—in the face of strong evidence that the three individuals were acting only to protect junior staff members—the draft report circularly concludes that "[t]he very fact the emails were ordered to be deleted . . . imply negative motives." Draft Report at 33. It further concludes (without any factual support) that the mere fact that "there was such an order issued" implies a "cover-up." *Id.* Finally, the draft report suggests that Ms. Wiley ordered the emails deleted in an effort to salvage her previous public statements "regarding the amount of work and effort ODG put forth in an attempt to secure funding for MYD." *Id.* at 34. Not only is that suggestion unfounded, it is demonstrably false. The draft report concludes that Ms. Wiley directed the email deletion in December, 2018. Her public statements, however, were not made until March, 2019.

None of this is an appropriate basis for reaching the extraordinary conclusion that government officials abused their authority. Any such conclusion should be based on concrete, factual evidence, and rooted in an established legal standard. It is unfair to government officials and to the residents of Detroit to base an "abuse of authority" conclusion on bald speculation, and on an indeterminate standard.

In short, as explained in further detail below, neither the law nor the facts support a finding of "abuse of authority."

I. The "Abuse of Authority" Standard

Although the draft report concludes that Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra "abused their authority," it nowhere provides a definition for that phrase. That omission severely undermines the draft report's conclusions. As the draft report itself recognizes, there is a difference between an "abuse of authority" and a more quotidian governmental misstep. *See* Draft Report at 2 (concluding that certain conduct was "not best practices or good governance," but "did not rise to the level of abuse of power").

That distinction is important. Government officials—like everyone else—sometimes suffer from "lapse[s] in . . . behavior," *Herman v. Dep't of Justice*, 193 F.3d 1375, 1381 (Fed. Cir. 1999), and "shortcomings" in performing their duties. *Chandler*, 817 N.Y.S. at 195. But not every such error by a government official is an "abuse of authority," and certainly not one that warrants a public reprimand or discipline. After all, if every single misstep by a government official constituted an "abuse of authority," it would be difficult for government to function—and difficult to recruit talented workers into government.

That is why, under accepted legal principles, the "abuse of authority" standard an exacting one. The phrase is rarely used in Michigan, except—in a reflection of its gravity—in the context of criminal exploitation of vulnerable victims. *See* MCL 777.40(3)(d). Generally, though, the phrase is understood to encompass only the most severe misconduct on the part of government officials. Some jurisdictions, for example, require a showing of "deliberate" misconduct. *See Fox v. Josephine Cty.*, No. 09-3067-CL, 2010 WL 3118703, at *7 (D. Or. Aug. 3, 2010) ("'Abuse of authority' is defined . . . as 'to deliberately exceed or make improper use of

delegated or inherent authority or to employ it in an illegal manner.'"). Other jurisdictions provide that "abuse of authority" connotes a "*continuing* violation," and a "pattern of misconduct." *See West v. Grant*, 662 N.Y.S.2d 863 (App. Div. 3d 1997) (emphasis added). Isolated, unintentional errors, then, generally do not rise to the level of "abuse of authority." *See id.*

Perhaps the best delineated standard (and one that has been widely adopted) comes from the federal whistleblower law, which provides that "[a]n abuse of authority requires an arbitrary or capricious exercise of power by a . . . official or employee that adversely affects the right of any person or that results in personal gain or advantage to himself or preferred other people." *Elkassir v. Gen. Servs. Admin.*, 257 F. App'x 326, 329 (Fed Cir. 2007). For an abuse of authority finding to be made under the federal whistleblower law, then, at least three conditions must be met:

- *First*, a government official or employee must be exercising "power."
- *Second*, the government official or employee must exercise that power in an "arbitrary or capricious" manner.
- *Third*, the "arbitrary or capricious" exercise of authority must either (1) "adversely affect[ ]" the rights of other people, or (2) result "in personal gain or advantage" to the government official/employee "or preferred other people."

Id. That standard, like others, presents a high hurdle to clear. And rightfully so. An "abuse of authority" finding, state and federal courts have concluded, should be reserved for "real wrongdoing"—not the "relatively minor misconduct of persons who happen to be cloaked with management authority." *Montgomery v. E. Corr. Inst.*, 377 Md. 615, 641 (2003); *see also Herman*, 193 F. 3d at 1381.

A few illustrative examples reinforce the point. Courts have held that "individual and idiosyncratic harassment" by a supervisor does not qualify as "abuse of authority." *Montgomery*, 377 Md. at 641. Nor does misappropriating government-issued electronic equipment for personal use. *D'Elia v. Dep't of Treasury*, 60 M.S.P.R. 226, 233 (M.S.P.B. Dec. 27, 1993). Even a series of relatively serious mistakes—like disclosing privileged materials, failing to make public records available under the Freedom of Information Act, and improperly authorizing payment to a government contractor—do not categorically qualify as "abuse of authority." *See Chandler*, 817 N.Y.S.2d at 194-195.

By contrast, knowingly approving falsified time sheets for a favored employee does qualify as an "abuse of authority." *D'Elia*, 60 M.S.P.R. at 234. So, too, does a government official knowingly and improperly engaging in self-dealing with his own business entity. *West*, 662 N.Y.S. at 863. And when a village mayor "refused to provide necessary funding for the Village's police department until . . . various criminal charges against him [were] resolved," that, too, qualified as an abuse of authority. *Greco v. Jenkins*, 989 N.Y.S.2d 153, 155 (2014).

The conduct at issue here—an isolated, benignly motivated directive for two junior staff members to delete unremarkable emails—pales in comparison to the conduct that courts have concluded are an "abuse of authority" As explained in further detail below, the facts contained

in the draft report do not rise to the level of "abuse of authority," as that term is generally understood. The draft report's assumption of improper motives, moreover, is entirely unsupported by the facts.

II. Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra did not Abuse Their Authority

A. Nothing in the Draft Report Suggests Improper Motive, Malignant Intent, or a Pattern of Misconduct

The draft report concludes that Ms. Wiley abused her authority because, in December 2018, she directed two low-level staffers to delete emails pertaining to Make Your Date. The report further concludes that Mr. Friedrichs and Ms. Abou-Chakra also "abused their authority" because they relayed Ms. Wiley's directive to those staffers.

Given those conclusions—and given the exacting standard for an "abuse of authority"—the draft report is more remarkable for what it does not say than for what it does.[2] There are at least three important indicia of "abuse of authority" that are conspicuously absent from the report:

First, there is no suggestion that the directive was part of a "pattern of misconduct." *Compare West*, 662 N.Y.S.2d 863 (App. Div. 3d 1997). The directive was a one-time order, given in December 2018, and reiterated in early 2019. By all accounts, the order to delete emails was an isolated incident.

Second, the draft report contains no basis for concluding that the directive to delete the emails was "deliberate" misconduct. *Compare Fox*, 2010 WL 3118703, at *7. Ms. Wiley, who purportedly gave the directive, did not view deletion of the emails as "wrong." Draft Report at 32. To the contrary, she "assumed the emails were deleted as part of the normal course of business." *Id.* at 30. Similarly, both Mr. Friedrichs and Ms. Abou-Chakra—who relayed the order to the junior staff members—did not think there was anything untoward about the deletion order. *See id.* at 30 ("Mr. Friedrichs told the OIG that he believed 'this was permissible under the laws and policies'"); *id.* at 32 ("Ms. Abou-Chakra sent an email to the OIG stating, in part[,] 'I

[2] A note about the facts at issue: There remain some factual questions about whether, and how, any "order" to delete emails was communicated. For example, Ms. Wiley's position is that she does not recall directing anyone to delete Make Your Date emails. Your draft report, however, concludes that it is "more likely than not" that "Ms. Wiley initiated the directive." Draft Report at 26.

This response assumes—without admitting—the facts as found in the draft report. Our contention is that *even if* the facts are as you have found them (e.g., that Ms. Wiley "initiated the directive," *id.* at 29), the conduct did not constitute an "abuse of authority." These arguments, however, should not be construed as an admission to, or an endorsement of, any of the factual conclusions reached in the draft report.

wholeheartedly believe that if I felt there was something incriminating or unethical in those emails, I would have pushed back on deleting them…'").

Third, the draft report nowhere suggests that there was anything incriminating or untoward in the emails themselves. Indeed, the emails (which have since been posted on the City's website) consist of entirely benign back-and-forths. *See* Recovered MYD Emails, *available online at* https://detroitmi.gov/sites/detroitmi.localhost/files/2019-08/Recovered%20MYD%20Emails.pdf.

There is, moreover, nothing to suggest that Ms. Wiley, Mr. Friedrichs, or Ms. Abou-Chakra *believed* that there was damaging information in the emails. As the draft report notes, Ms. Abou-Chakra understood that "there was nothing to hide in the emails," and they "would show the ODG did what they were supposed to do." *Id.* at 32. Similarly, Mr. Friedrichs believed that the emails refuted the "appearance that something happened." *Id.* And all three officials "stated that the City of Detroit and ODG did nothing improper or unethical regarding MYD." *Id.*

These words were backed up with action. Crucially, Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra never deleted their *own* emails. *See id.* at 31 ("Mr. Friedrichs did not delete his MYD emails"); 31-32 ("Ms. About-Chakra . . . did not delete any MYD emails"). If the purpose of the deletion order was to "cover up" correspondence between the City of Detroit and Make Your Date, *see id.* at 33, it would make no sense for the order to pertain only to very junior staffers—but for senior appointees in the Mayor's administration not to delete their own emails.

And, contrary to the draft report's suggestion that there was a "cover up," Draft Report at 33, the draft report itself notes that City of Detroit personnel went to great lengths to recover the emails once they learned the emails had been deleted. *Id.* at 33-34. Indeed, it bears emphasis that not only did the City *recover* the emails, it *posted them publicly* on its website. Those actions are not consistent with a "cover up." *Id.* at 33.

Yet despite a total lack of evidence, the draft report speculates that the email-deletion directive was part of a malignant scheme. To be sure, the draft report does not reach an express conclusion as to *why* the emails were deleted. But it does "suggest" that "[t]he very fact the emails were ordered to be deleted and were deleted imply negative motives." *Id.* at 33. It further speculates, without any support, the "deletion of emails was a cover-up." *Id.*

The draft report's suggestion of improper motive, however, is belied by the factual record laid out in the report itself. Over and over again, the draft report suggests that the deletion order was rooted in a desire to protect junior staff members from becoming embroiled in negative press coverage. Specifically, Mr. Friedrichs—whose statement the OIG expressly found "credible"—told the OIG that "he believes Ms. Wiley 'meant well' and was merely trying to protect the ODG staff." *Id.* at 29; *see also id.* at 31 (Mr. Friedrichs "stated that he understood asking 'the 20 year olds . . . to delete their emails to protect them."). Similarly, Ms. Abou-Chakra stated that she understood the directive was to "protect the staff so there were not emails out there to bring their names into it." *Id.* at 32. For her part, Ms. Wiley did not recall ordering the emails deleted. But her statements also imply that her intention was to protect junior staff members from being swept up in an unsavory media narrative. *See id.* at 28 ("Ms. Wiley noted

that with 'Bob Carmack and all of the craziness going on,' the intention was that the ODG grant team should stop reaching out to MYD.").

Inexplicably, however, the draft report discounts all of these statements, even those it deems "credible." *See id.* at 29. Rather than embrace the straightforward conclusion that the deletion directive was meant to protect junior staffers, the draft report suggests that Ms. Wiley ordered emails deleted because "the recovered emails contradict statements made by Ms. Wiley regarding the amount of work and effort ODG put forth in an attempt to secure funding for MYD." *Id.* at 34. That suggestion is wholly speculative, and is not backed up by any concrete factual evidence. *Nothing* in the draft report suggests that Ms. Wiley was motivated by her public statements. There is no evidence to suggest that Ms. Wiley was at all concerned about the statements she had made to the press, or that she was worried about whether those statements were consistent with the email record. What is more, Ms. Wiley was not copied on the emails that were deleted. There is no indication that she was aware of the emails' contents. The theory that Ms. Wiley (driven by a motivation that there is no indication she had) ordered emails deleted (when there is no indication she knew what they said) in order to cohere to her press statements is speculation layered atop speculation.

In any event, Ms. Wiley's public statements were *not* contradicted by the emails. The draft report suggests that Ms. Wiley "misled" the public when, in an April 4 press release, she stated that the City did not "participate in any fundraising effort for Make Your Date nonprofit," and that "all efforts were a direct collaboration with university staff for the university-run program." Draft Report at 15-16; *see* Draft Report at 36. As evidence that she "misled" the public, the draft report cites two facts. *First*, it notes that Make Your Date received a grant from the Carls Foundation, aided by City staff. *Id.* at 16. *Second*, it notes that City funds were "allocated to MYD participants . . . to pay for Lyft rides." *Id.* at 2.

But neither of these facts actually contradicts Ms. Wiley's public statements. Consistent with Ms. Wiley's statement, the Carls Foundation grant *was* a "direct collaboration with university staff for the university-run program." *Id.* at 15. It was the university-run program that received the grant. And the Lyft partnership had been announced nearly two years before Ms. Wiley's public statements. The press release about that partnerships specifically noted that "participating expecting moms will be able to use the Lyft app to arrange transportation to their doctor's appointments, SisterFriends meetings and MYD education sessions." Lyft Partnership Press Release, Aug. 16, 2017. The idea that Ms. Wiley sought to suppress the emails to mislead the public about facts that had already been made public beggars belief.

And not only is the draft report's speculation about Ms. Wiley's motives unsupported by facts, it is contradicted by the timing of the deletion order. The first deletion directive was made in December 2018, "soon after surveillance video of Mayor Duggan was broadcast outside of the Coleman A. Young Center." Draft Report at 27. The directive was reiterated on February 7, 2019. *Id.* Ms. Wiley, however, did not make any public statements regarding Make Your Date fundraising until late March and early April of 2019. *See id.* at 15 (quoting April 2 statement); *see also* Joe Guillen and Kat Stafford, *City Fundraising Office Deleted Emails About Nonprofit Tied to Detroit Mayor Mike Duggan*, The Detroit Free Press, July 12, 2019 (quoting March 29,

2019 email from Ms. Wiley to the Detroit Free Press). It makes no sense to suggest that Ms. Wiley ordered deletion of the emails in December of 2018 to make the email record consistent with statements she had *not yet made*.

The facts thus support the simplest, most straightforward explanation. As Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra all suggested, the deletion directive was meant to protect junior staffers from unsavory media attention. Nothing suggests that the deletion directive was a "cover-up," or driven by "negative motives." It is unfair to conclude, based on disprovable speculation about Ms. Wiley's motivations, that the deletion directive a "cover-up" or motivated by a malignant purpose.

B. The Conduct at Issue Did Not Constitute an Abuse of Authority

Given all of this, Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra's conduct does not meet any cognizable "abuse of authority" standard. As noted above, there are no facts to support the conclusion that the directive was part of a "pattern of misconduct." *Compare West*, 662 N.Y.S.2d 863 (App. Div. 3d 1997). Nor is there any basis for concluding that there was "deliberate" misconduct. *Compare Fox*, 2010 WL 3118703, at *7.

The conduct also plainly does not meet the standard for "abuse of authority" adopted in the federal whistleblower law. Again, for an "abuse of authority" to occur, a government official must (1) exercise power, (2) in an "arbitrary or capricious" manner, that (3) either "adversely affects" the rights of other people, or results in "personal gain or advantage" to the government official "or other preferred people." *Elkassir*, 257 F. App'x at 329.

None of those prongs are satisfied here.

1. Mr. Friedrichs and Ms. Abou-Chakra Did Not "Exercise Power"

First, it is far from clear that all three of the officials "exercised power" in the first place. The draft report concludes that Ms. Wiley gave an order to delete emails. But Mr. Friedrichs and Ms. Abou-Chakra simply "relayed" and "reiterated" those instructions. Draft Report at 3. Government officials, courts have made clear, are not "exercising power" when they act pursuant to a directive that has already been given by someone in a position of authority. *D.C. v. Poindexter*, 104 A.3d 848, 857 (D.C. 2014). Mr. Friedrichs and Ms. Abou-Chakra thus did not "exercise power" at all.

That conclusion is true for Mr. Friedrichs, and it is inescapable for Ms. Abou-Chakra. Ms. Abou-Chakra, after all, was not just passing along an order that (the draft report concludes) originated from Ms. Wiley. She was passing along that order at the request of Mr. Friedrichs, to whom she directly reported. Ms. Abou-Chakra, in other words, was relaying an order at the direction of a superior. Ineluctably, such activity does not constitute an exercise of power, and certainly not an "abuse of authority."

In all events, there is no indication that the email-deletion directive originated *either* with Mr. Friedrichs or Ms. Abou-Chakra—and the draft report itself concludes that it did not. Neither

Mr. Friedrichs nor Ms. Abou-Chakra, therefore, "exercised power." For that reason alone, they did not "abuse authority."

2. None of the Three Officials Acted Arbitrarily or Capriciously

Second, even if all three officials can be said to have "exercised power," they certainly did not do so in an "arbitrary or capricious" manner. There is no indication (and no finding in the draft report) that the deletion of emails violated any law or policy. Nor is there any indication that Ms. Wiley, Mr. Friedrichs, or Ms. Abou-Chakra believed that deletion of emails was disallowed. In fact, just the opposite is true. As Mr. Friedrichs told the OIG, he believed email deletion "was permissible under the laws and policies." *Id.* at 31. Similarly, Ms. Wiley "assumed the emails were deleted as part of the normal course of business." *Id.*

It may have been bad judgment to order the emails deleted. *See id.* at 32. But misjudgments are not an "arbitrary or capricious" exercise of power. *See Montgomery,* 377 Md. at 641. None of the evidence suggests that Ms. Wiley, Mr. Friedrichs, or Ms. Abou-Chakra thought that there was anything incriminating in the emails. Nothing suggests that, in giving the order, they were motivated by a desire to cover up the relationship between the City and Make Your Date. Indeed, all three officials believed that there was nothing untoward about that relationship. And all three officials kept their own emails—with Mr. Friedrichs going so far as to refer to those emails as exculpatory "armor." *Id.* at 31.

The evidence thus suggests that any order to delete the emails was motivated by a sincere desire to protect two junior staffers—young women at the start of their careers—from having their names associated with a sensationalistic media story. The order to delete emails may well have been misguided, and fallen short of best practices regarding government transparency. But that does not render the order "arbitrary and capricious." There was no desire to harm; no attempt to cover up damaging information; no effort to shield administrative appointees from criticism. If every isolated error in judgment by a government official qualifies as "arbitrary and capricious," that phrase has no meaning.

A final note on the "arbitrary and capricious" topic. Following the discovery that emails related to Make Your Date were deleted, the City, via Executive Order, adopted a new policy which clarifies that emails related to city business must be retained for a minimum of two years. Executive Order 2019-1 (July 3, 2019). Issuance of that executive order buttresses the conclusion that there were no policies governing email retention when the deletion order was given. The order, moreover, undercuts any lingering question as to whether the deletion directive was "arbitrary and capricious." When a mistake is made, then is quickly rectified via policy, it is not "arbitrary and capricious" governance.

3. The Email Deletion Order Did Not Result in Personal Gain or Advantage, or Adversely Affect Other People's Rights

Finally, there is nothing to suggest that the order to delete the emails "adversely affected the rights of other people"—or resulted "in personal gain or advantage" to the three officials "or preferred other people." *Elkassir,* 257 F. App'x at 329. Again, the order to delete emails was

directed only at junior staffers. Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra did nothing at all with respect to their own emails. That fact alone belies any conclusion that the deletion order was motivated by "*personal* gain or advantage." *Id* (emphasis added). There is, moreover, no indication that Ms. Wiley, Mr. Friedrichs, or Ms. Abou-Chakra benefited personally from the email deletions. Though the draft report strains to suggest that Ms. Wiley may have been motivated by a desire to make the record consistent with her public statements, that speculation is unsupported by any facts, and belied by the timeline of the directive. *See supra* II.A.

And the order to delete emails did not result in "personal gain or advantage" to any "preferred other people." *Elkassir*, 257 F. App'x at 329. To be sure, the order to delete the emails was motivated by a desire to shield two junior staffers from involvement in an unsavory news story. But there is no indication that Ms. Huttenlocher or Ms. Phillips were directed to delete their emails because they were "preferred" employees. *Any* junior staffer who had corresponded with Make Your Date would, presumably, have been subject to a similar order. Nothing in the draft report suggests that Ms. Huttenlocher or Ms. Phillips were singled out for special treatment because they were "preferred" people.

The two junior staffers who were asked to delete their emails, moreover, did not realize any pecuniary or tangible benefits. They were not promoted, nor were their careers advanced, as a result of the email-deletion directive. At most, the deletion of the emails would have allowed Ms. Huttenlocher and Ms. Phillips to remain relatively anonymous, and to continue to enjoy relative peace of mind without being swept into an unsavory media narrative. But courts have made clear that the attainment of subjective feelings—happiness, contentment, peacefulness, and the like—do not qualify as "personal gain or advantage." *See Manning v. Temple Univ.*, No. CIV.A. 03-4012, 2004 WL 3019230, at *10 (E.D. Pa. Dec. 30, 2004), aff'd, 157 F. App'x 509 (3d Cir. 2005) ("Whatever else personal gain or advantage may be, it does not include. . . pleasure one may obtain"); *see also United States v. Santiago*, 604 F. App'x 57, 58 (2d Cir. 2015) (noting that a defendant lied "out of a misguided sense of loyalty . . . *rather than* for personal gain or advantage") (emphasis added).[3]

The contrast with cases that have found an "abuse of authority" could hardly be plainer. Conduct that can constitute an "abuse of authority" includes signing off on a fraudulent time sheet, *D'Elia*, 60 M.S.P.R. at 234, engaging in self-dealing, *West*, 662 N.Y.S. at 863, or threatening to withhold funds to a city department in exchange for a favorable outcome in an investigation. *Greco*, 989 N.Y.S.2d at 155. Those fact patterns are entirely unlike the facts laid out in the draft report.

[3] In addition, it bears emphasis that the "abuse of authority" standard requires that an arbitrary and capricious exercise of power *result* in "personal gain or advantage." Even if preserving anonymity and peace of mind can be considered "personal gain or advantage," Ms. Huttenlocher and Ms. Phillips plainly did not realize that "gain." Both women's emails have been posted publicly online, and the two women have been the subject of multiple news stories about Make Your Date. *See, e.g.,* Christine Ferretti, Jennifer Chambers, and Alex Nester, *City Releases Previously Deleted Emails Tied to Make Your Date Nonprofit,* The Detroit News, Aug. 2, 2019.

Finally, there is no suggestion, in the draft report or elsewhere, that the deletion of the emails "adversely affect[ed] the rights of any other person." *Elkassir*, 257 F. App'x at 329. Nobody was harmed or disadvantaged by the deletion order, and certainly no "person" suffered a diminution of his or her rights as a result.

There is, in short, no basis to conclude that the directive was an "abuse of authority."

***

For the foregoing reasons, Ms. Wiley, Mr. Friedrichs, and Ms. Abou-Chakra did not "abuse their authority," as that phrase is commonly understood. This is not to say that the order to delete the emails was wise, or was in keeping with the best practices relating to "transparent and open government." Draft Report at 32. It was not.

But there is a difference between an error in judgment and an abuse of authority. That is why courts and tribunals have set such an exacting standard for a finding of "abuse of authority." That standard has not been met here. It is unfair to the three officials—and damaging to the function of City government—to make such a finding without clear reference to any standard, and on the basis of easily refuted speculation about Ms. Wiley's motivation. We thus ask that you rescind your preliminary finding that those three officials abused their authority.

CONCLUSION

There is no way a draft report, pulled together in a limited period of time, can be expected to capture the full breadth of the science, medicine, policy, nonprofit law, state LMCH procurement procedures, and months of media communications. Understandably, then, the draft report's understanding of many these issues is incomplete or incorrect.

But complexity regarding the underlying issues should not obscure the simple, straightforward conclusion that the OIG investigation should reach. The original questions posed by the investigation was whether the Make Your Date non-profit received any "preferential treatment," and whether Detroit officials "potentially abused their authority by providing [that] preferential treatment." The clear answer to those questions is "no." The Make Your Date non-profit was not the beneficiary of any city resources, and—accordingly—there was no abuse of authority relating to that non-profit.

We respectfully submit that the report's analysis should end there. An OIG report is an enormously powerful document that can damage individuals' reputations and careers. We hope the discussion contained herein will be taken seriously, and that the Final Report will be revised so that erroneous conclusions from the OIG do not compound the damage that has already been done to these individuals via widely circulated media reports.

Affidavits of Truthfulness

AFFIDAVIT OF TRUTHFULNESS

I, Michael E. Duggan, am a person affected by Draft OIG Report in Case No. 19-0013-INV ("Draft Report"). The attached "Response to OIG Draft Findings, Case No. 19-0013-INV," dated October 14, 2019, serves as my written response to the Draft Report.

I hereby swear that the factual statements in the "Response to OIG Draft Findings, Case No. 19-0013-INV" are true to the best of my knowledge.

Mayor Michael E. Duggan

Sworn to before me this 14 day

of October, 2019.

NOTARY PUBLIC

Anthony Dwight House
NOTARY PUBLIC
Durham County, North Carolina
My Commission Expires 10/13/2019

AFFIDAVIT OF TRUTHFULNESS

I, Alexis Wiley, am a person affected by Draft OIG Report in Case No. 19-0013-INV ("Draft Report"). The attached "Response to OIG Draft Findings, Case No. 19-0013-INV," dated October 14, 2019, serves as my written response to the Draft Report.

I hereby swear that the factual statements in the "Response to OIG Draft Findings, Case No. 19-0013-INV" are true to the best of my knowledge.

Alexis Wiley

Sworn to before me this 14 day of October, 2019.

11/2025

NOTARY PUBLIC

Brandi C Shelton
Notary Public
Oakind County acting in Wayne

AFFIDAVIT OF TRUTHFULNESS

I, Ryan Friedrichs, am a person affected by Draft OIG Report in Case No. 19-0013-INV ("Draft Report"). The attached "Response to OIG Draft Findings, Case No. 19-0013-INV," dated October 14, 2019, serves as my written response to the Draft Report.

I hereby swear that the factual statements in the "Response to OIG Draft Findings, Case No. 19-0013-INV" are true to the best of my knowledge.

Ryan Friedrichs

Sworn to before me this 14 day

of OCTOBER, 2019.

11/2025

NOTARY PUBLIC

Brandi C Shelton
Notary Public
Oakind County acting in Wayne

AFFIDAVIT OF TRUTHFULNESS

I, Sirene Abou-Chakra, am a person affected by Draft OIG Report in Case No. 19-0013-INV ("Draft Report"). The attached "Response to OIG Draft Findings, Case No. 19-0013-INV," dated October 14, 2019, serves as my written response to the Draft Report.

I hereby swear that the factual statements in the "Response to OIG Draft Findings, Case No. 19-0013-INV" are true to the best of my knowledge.

Sirene Abou-Chakra

Sworn to before me this 14 day

of October, 2019.

11/ 2025

NOTARY PUBLIC

Brandi C Shelton
Notary Public
Oakind County

Acting in Wayne

Attachment 1

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

P.O. BOX 30214
LANSING, MICHIGAN 48909

DANA NESSEL
ATTORNEY GENERAL

October 8, 2019

Dinsmore & Shohl LLP
900 Wilshire Drive, Suite 300
Troy, MI 48084

Re: Make Your Date, Inc. CT 60741

Dear Sir/Madam:

Thank you for submitting initial forms and related information. Determinations are based on Michigan laws for registering charities, the Charitable Organizations and Solicitations Act (COSA), MCL 400.271 *et seq*. and the Supervision of Trustees for Charitable Purposes Act (STCPA), MCL 14.251 *et seq*.

It appears this organization does not compensate staff or independent contractors for services related to fundraising. Additionally, the organization does not solicit or receive contributions in excess of $25,000 in a 12-month period. Therefore, registration is not required under COSA. If in the future, staff or independent contractors are paid for services related to fundraising or contributions exceed $25,000 in a 12-month period, notify our office as registration likely will be required. COSA registration is separate from requirements of other agencies.

According to information submitted, the organization is incorporated in Michigan and/or holds assets in Michigan to use for charitable purposes. The organization is now registered under STCPA. Normally, financial accountings must be filed six (6) months following the close of each fiscal year. However, you requested and were granted a 7-year waiver of the annual reporting requirement. As long as the organization qualifies under **all** waiver conditions, financial filings will not be required for 7 years. At the end of the 7th year, the organization must resubmit a waiver request. The Attorney General reserves the right to request waived accountings if questions arise.

This letter will be retained to show notification of our requirements. If you have questions, view our website at www.michigan.gov/charity or contact our office.

Department of Attorney General
Charitable Trust Section
(517) 335-7571

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#00000001326146v1

Attachment 2

Response of WSU General Counsel to Detroit Free Press Story of April 14, 2019

Today's Detroit Free Press story regarding the Make Your Date program grossly misrepresented the facts. Detroit has the highest preterm birth rate in Michigan. Pregnant women in this city deserve access to the latest medical research and education to help them have healthy babies. That's why the City of Detroit turned to Wayne State University, the leading university in the nation in this field, to help develop a program to help reduce preterm birth. The Free Press story is factually wrong: no city funds were ever provided to a Make Your Date non-profit and no private money was ever raised for it. Every dollar of city funds went directly to Wayne State University. The reporters knew, but failed to include, that Dr. Hassan, a nationally known expert in preventing preterm birth, provided her expertise to Make Your Date on a completely voluntary basis. She never accepted a dime from the program. Every dollar provided to Wayne State went to direct services for women enrolled in the program. One thing the story got right is that "there has been no suggestion that Make Your Date or Hassan have misused any funds." The bottom line is this. The City of Detroit worked with Wayne State University to develop a program to help high risk women to deliver healthy babies. Dr. Hassan didn't receive any compensation from Make Your Date to help in this effort. Our actions as a city have been completely proper. No ethics rule, law or ordinance have been violated in the city's support for Make Your Date.

Attachment 3

Affidavit of Dr. Robert J. Sokol

Dr. Robert J. Sokol, first being duly sworn, deposes and says:

1. I am the former Dean of the Wayne State University School of Medicine. I currently serve as Adjunct Professor of Epidemiology and Bio Statistics for the Michigan State University College of Human Medicine, as well as Emeritus Distinguished Professor at Wayne State University (WSU).

2. For 36 years at WSU, I worked as a physician and scientist, focused primarily on maternal and child health in the City of Detroit, at Hutzel Hospital, and on the applicability of that research to treat pregnant mothers and their babies around the world. In that time I held the following positions:

   a. 1983-1988 Chair of the WSU Obstetrics and Gynecology (OB/GYN) Department.
   b. 1988-1999 Dean, WSU School of Medicine
   c. 2000-2011 WSU Project Site Manager for National Institutes of Health (NIH) Perinatology Research Branch (PRB)
   d. 1999-2018 Director of C.S. Mott Center at WSU, conducting and overseeing the laboratory research for maternal and child health for the WSU Department of Obstetrics and Gynecology and the PRB.

3. I am the Chair of the State of Michigan's Maternal Mortality Medical Committee that reviews the deaths of women in childbirth. I have served on the State's review committee for the last 36 years.

4. I have reviewed the draft opinion of the OIG, particularly pages 15-26 in which it is suggested that the City of Detroit gave "preferential treatment" to the Make Your Date program for not giving adequate consideration to other possible providers who could do the same thing. I can tell you from a medical and scientific perspective, that conclusion is completely false. For 36 years I have seen every single initiative in Michigan to reduce preterm birth and infant mortality. Some have had limited success, most have had no success at all. Those initiatives have always been woefully under resourced and usually not based on hard, scientific data on how to reduce infant mortality.

5. The idea of taking the enormous medical and research resources of Wayne State University and the National Institutes of Health and putting them to work directly for the high-risk mothers of Detroit was transformational. There is no factual basis to suggest that any other organization exists that could possibly have combined a huge patient base, large medical faculty practice group, and direct access to NIH researchers on high-risk pregnancies, all to care for pregnant mothers in Detroit.

6. In my professional opinion, it was not "preferential treatment" to select WSU's Make Your Date program, backed by the university and NIH research to help address Detroit's tragic preterm birth and infant mortality rates. It was the only rational choice and it was a decision long overdue. The recent research documenting the reduction of preterm births among Make Your Date patients demonstrates the wisdom of that decision. For a scientist practicing in this field, creating Make Your Date was obviously the correct policy decision from the beginning.

7. In 1993, Congress established the Perinatology Research Branch (PRB) of the National Institutes of Health (NIH) in Washington, DC. Perinatology is the branch of medicine that focuses on the health of the mother and baby prior to and shortly after pregnancy. It focuses on high-risk pregnancies in which the health of the mother or baby are particularly fragile. The NIH PRB is arguably the leading research institution in the world for preventing preterm birth and infant and maternal death.

8. In 2000, the NIH began a process to find a permanent home for the PRB and opened up a national competition. The NIH would be providing more than $140 million in research funds over the next decade to whichever institution was selected as the host and the result was the finest medical schools in America vigorously competed for the honor.

9. I led the team putting forth WSU's proposal for the PRB. WSU had a highly accomplished OB/GYN faculty, located in Detroit, the city that tragically had the highest preterm birth and infant mortality rates in America. We proposed that the PRB be based out of Hutzel Hospital, where 5,000 babies were delivered each year, a huge proportion of whom were to poor, African American, and/or high-risk mothers. WSU beat out Yale and other universities to be selected as the host to the PRB, bringing the WSU medical school its largest research funding in the school's history.

10. In 2012, the NIH opened a national competition to determine whether the PRB should continue at WSU or be relocated to another institution. I co-led the effort to retain the PRB at WSU. In 2013, WSU was awarded another 10- year contract by the NIH, this time for $167 million in research. WSU has literally been the world's center for research on preterm birth and infant mortality as well as other pregnancy complications for nearly two decades.

11. In 2013, I stepped down as Project Site Manager for the PRB and Dr. Sonia Hassan succeeded me, leading the entire WSU research team. Under her tenure, the PRB has made groundbreaking discoveries in treatments for pregnant women. Dr. Hassan is internationally recognized as a leading researcher in the field of reducing preterm birth and infant mortality.

12. Throughout my time at WSU, there has been no greater source of personal pain than the tragically high maternal and infant mortality rate suffered by babies in the City of Detroit. From my arrival in Detroit 36 years ago, African American babies have died twice as often as Caucasian babies and Detroit babies have died twice as often as other babies in Michigan.

13. Throughout the decades, the City of Detroit Health Department has been less than highly effective in implementing any public health strategy to close this gap in my opinion. At WSU, we had to partner with hospitals to develop public health strategies on our own because there was never an effective or properly-resourced Detroit Health Department effort to address this problem. The frequency of Detroit babies delivered to alcoholic mothers was so severe, in 1986, I convinced the NIH to fund the Fetal Alcohol Research Center, which I started at WSU, the only one in the country at the time (maternal drinking increases the risk of preterm birth).

14. There is a critical need for a community strategy driven by the Detroit Health Department – too often our doctors don't see pregnant moms until late in pregnancy and sometimes, not until they show up at the emergency room at the time of delivery. Over the years, the Detroit Health Department made a number of efforts at public information campaigns, but never in the time I was at WSU did I see ever see the city act with evidence-based, data-driven strategies that effectively addressed prematurity-related infant mortality.

15. Infants in Detroit are dying at twice the rate of the rest of Michigan, yet the mothers had no way to access the medical advances that were being developed since 2002 by the NIH and WSU in Hutzel Hospital in their own community. Dr. Hassan set out to correct that inequity in early 2014 by setting up a nonprofit, which undoubtedly would have done some good. But before Make Your Date got started, Dr. Hassan realized how much more could be accomplished if WSU ran the program. She essentially scrapped the nonprofit before the program started and turned the development and operation of Make Your Date over to WSU.

16. On page 15 of the draft OIG report, the difference between the nonprofit and WSU is called, **"a distinction without a purpose"**. This is nonsense! The difference is profound. It is a comparison of the resources of a newly-formed nonprofit versus a University affiliated with the most renowned perinatal research center in the world. WSU is a $1 billion a year institution whose President, Roy Wilson, is a former NIH executive who has personally strongly backed WSU's Make Your Date program. The WSU School of Medicine has strongly supported Make Your Date's efforts through its medical staff. The NIH has committed $167 million in research funding on preventing infant mortality and preterm birth in its current contract with WSU to be done at the PRB center in Hutzel Hospital in Detroit. What WSU did with Make Your Date was to create the bridge for high-risk pregnant mothers in Detroit to access all those resources in a coordinated way. No non-profit can compare to that level of resource commitment – it is a huge distinction.

17. WSU's five year history running Make Your Date is a source of immense pride to the university. WSU President Wilson has cited its accomplishments repeatedly in public speeches. Make Your Date's success has been reported by WSU at major international medical conferences and has been featured in its continual updates to the NIH on the value being provided in the community. The failure of the OIG draft report to clearly credit WSU for its role as the developer and operator of Make Your Date is nothing short of disrespectful to the accomplishments of the university.

18. WSU's Make Your Date program has four essential components in providing services to expectant mothers:

a. Support by telephone to answer patients' questions throughout their pregnancies, whether problems with getting appointments, medications, insurance, or any other issues that arise.

b. Education programs for pregnant mothers at the Hutzel Clinic and the PRB center on what to do with common pregnancy discomforts, how to eat, how to make sure the pregnancy is properly monitored, the importance of prenatal care, and steps the mother can take to help insure the baby is brought to full term.

c. Making certain that all pregnant moms are screened for a short cervix, that is associated with a very high rate of preterm birth.

d. Referral to the NIH research resources at the PRB. High-risk pregnant moms get even more intensive physician interaction with the country's leading research doctors on preterm birth when they participate in the NIH research programs. Nowhere else in America can a low-income, high risk mother go into their OB's clinic and be seen at no cost at the country's center of perinatal research.

19. Page 20 of the draft report reads: **"Based on the OIG investigation, there are other agencies that could have provided similar services."** The draft report does not identify who these other agencies might be, but I can state with certainty that statement is completely false. That statement reflects a lack of medical understanding on the services provided by Make Your Date. WSU's ownership of Make Your Date provided three major resources that could not have been provided by any other agency in Michigan, and likely not anywhere else in America:

a. WSU has a large OB/GYN Medical Department and affiliated practice, with about 40 faculty physicians, 40 residents, and 10 midwives. They provide medical care to Michigan's largest patient base of African-American, low-income, and high-risk pregnant mothers. The patients are nearly all seen at WSU-affiliated centers – either at the University Health Center Clinic at Hutzel Hospital or at the PRB research center at Hutzel Hospital. That means approximately 2,000 at-risk mothers came through one location each year to be seen by WSU medical staff, providing the opportunity for WSU Make Your Date staff to run pregnancy education programs for patients along with their pre-

scheduled medical or research visits. Historically in Detroit, well-meaning patient education campaigns to reduce infant mortality have failed because they have only been able to reach small groups of women in small community settings. WSU created a breadth of educational outreach in Make Your Date that I never have seen in Michigan, by coordinating with the medical and research visits to the WSU physicians and by helping ensure access to care with provision of transportation and other support.

b. A key component of Make Your Date is access to "group appointments", where a group of pregnant moms meet with their doctor/midwife together, instead of the traditional one-on-one appointments. WSU has been part of national research led by Yale University that has found major reductions in pre-term births when patients form bonds in group sessions. The WSU Ob/Gyn Department created a group-care practice run by its midwives so that pregnant moms would have this option. Make Your Date staff educated pregnant mothers on the WSU group-care option, made referrals directly into the program, and scheduled the patients' appointments. Only a major health care practice like the WSU Ob/Gyn group could have created such care options – no non-profit I am aware of has that capacity.

c. Pregnant moms who are treated by WSU medical staff are each given the opportunity to be referred to the NIH PRB research center at Hutzel Hospital for the term of their pregnancy. At the PRB, the world's most advanced medical researchers and can provide additional support for very high risk pregnancy conditions, which is extremely valuable for women who previously experienced growth-restricted pregnancies, miscarriages, or fetal deaths. The PRB site provides more frequent patient interaction, particularly after 24 weeks, watching for early signs of pregnancy complications. The increased surveillance and diagnostics from the PRB staff often provide early warnings of developing problems and lead to immediate referral to the emergency room or the patient's physician treating for pregnancy-saving interventions. The NIH's PRB is located in only one place in America – at WSU at Hutzel Hospital. There is literally nowhere else in the U.S., let alone in Detroit, that a high-risk mother can get access to their advanced pregnancy surveillance and diagnostics. WSU's Make Your Date coordinates referral of pregnant moms to WSU researchers at the PRB center.

20. The draft OIG report gives the impression that $350,000 in grant funding to Make Your Date was the essence of the services. Nothing could be further from the truth. A $350,000 grant by itself wouldn't even pay for a doctor and a nurse for a year. Make Your Date has been successful only because of the enormous resources of WSU, backed up by the NIH's national research. WSU made these resources available to thousands of Make Your Date clients in addition to the small grant contribution from the city.

21. The only way any report could credibly claim that WSU got "preferential treatment" in the city's support of the Make Your Date program would be to demonstrate what other potential non-profit or agency was out there that could have possibly brought all these resources directly to thousands of pregnant mothers based on a small city grant. There was and is no such alternative.

22. The success of WSU's extraordinary efforts in running the Make Your Date program have now been documented by the highly respected scientist, Dr. Adi Tarca, and his research team at Wayne State University. His research shows that for the approximately 2,000 women served in 2014 and 2015, Make Your Date mothers were 37% less likely to deliver at under 32 weeks than non-Make Your Date mothers at the same hospital. Make Your Date mothers were 28% less likely to deliver at under 34 weeks. As scientist who has worked in this field for decades, I can say without hesitation that these early results are remarkable. (Summary Attached) This confirms the previous efficacy trial (Article Attached) and demonstrates clinical effectiveness – it is a massive, truly remarkable decrease in a major perinatal adverse outcome.

23. In 2003, the Board of Directors of the Detroit Medical Center publicly announced its decision to close Hutzel Hospital because of huge financial losses, which would have created human tragedy for many of the 5,000 high risk moms and babies treated at the hospital each year. By the time Mike Duggan was named as the CEO of DMC in 2004, the closing of Hutzel had already been accepted as a foregone conclusion. The new CEO shocked many of the long-time medical staff at Hutzel when he told them at the first meeting that he was going to do everything he could to get the DMC Board to reverse its decision and keep Hutzel open for the Detroit community. What he demanded from the doctors and employees at DMC was a much higher level of service every day, change he drove with metrics-driven, evidence based decision. We changed the performance of Hutzel Hospital and that institution still continues to serve the City of Detroit 16 years after its announced closure.

24. It is extremely unusual to have a Mayor who is himself highly knowledgeable in the science and practice of delivering care to high-risk mothers. I read with interest the complaints from city employees about Mayor Duggan's efforts to fundamentally change the city's practices in providing care to pregnant moms. It is a reaction familiar to many who were at DMC when he first arrived and started demanding higher levels of performance from everyone. For decades, the City of Detroit's infant mortality rate has not only been among the highest in America, our babies die at rates higher than many third world countries. You would hope that employees at the Detroit Health Department would be embarrassed at that record and would embrace evidence-based change. You would hope that employees in the grants department would consider raising funds to save babies' lives to be their highest calling and not a nuisance they were being pressured to perform. But what I see is a Mayor of Detroit who has taken the initiative to finally demand that the City of Detroit respond to the infant mortality crisis with evidence-based medicine

and strategies that have been proven to be effective. If I fault Mayor Duggan for anything, it is for not doing more to support Make Your Date. While Make Your Date has been extremely effective for those moms who got its services, fewer than 10% of Detroit's pregnant moms were enrolled. To make a meaningful impact on the overall infant mortality rate in Detroit, it is critical that Make Your Date be resourced sufficiently to be available to all pregnant mothers in the city.

25. If there is any doubt on my opinion on this issue, I would strongly encourage the OIG to interview Dr. Roberto Romero, a federal official who serves as the NIH's head of the PRB and probably the most esteemed researcher in America on preventing preterm birth and infant mortality. He has been in Detroit with the PRB for 17 years and I am certain would also dispel the wholly inaccurate medical conclusions in the OIG draft report that any other provider could have matched the impact of Make Your Date as a city-supported program. I would be glad to make myself available for an interview with the OIG staff to elaborate on these matters further. I am confident when the OIG understands the medical and science aspects of this issue, it will be obvious that Mayor Duggan's actions in no way constituted preferential treatment. To the contrary, they provided the most effective efforts to reduce preterm birth that I have ever seen.

The foregoing is based on my own personal knowledge and, if called, I could competently testify thereto.

Dr. Robert J. Sokol

Sworn to before me this 10th day of OCTOBER, 2019

NOTARY PUBLIC

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NOTARY PUBLIC, STATE OF MI
COUNTY OF MACOMB
MY COMMISSION EXPIRES Aug 8, 2024
ACTING IN COUNTY OF OAKLAND

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Vaginal progesterone reduces the rate of preterm birth in women with a sonographic short cervix: a multicenter, randomized, double-blind, placebo-controlled trial

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KEYWORDS: pregnancy; preterm delivery; preterm labor; progestins; progestogens; respiratory distress syndrome; transvaginal ultrasound; uterine cervix; vaginal administration

ABSTRACT

Objectives *Women with a sonographic short cervix in the mid-trimester are at increased risk for preterm delivery. This study was undertaken to determine the efficacy and safety of using micronized vaginal progesterone gel to reduce the risk of preterm birth and associated neonatal complications in women with a sonographic short cervix.*

Methods *This was a multicenter, randomized, double-blind, placebo-controlled trial that enrolled asymptomatic women with a singleton pregnancy and a sonographic short cervix (10–20 mm) at 19 + 0 to 23 + 6 weeks of gestation. Women were allocated randomly to receive vaginal progesterone gel or placebo daily starting from 20 to 23 + 6 weeks until 36 + 6 weeks, rupture of membranes or delivery, whichever occurred first. Randomization sequence was stratified by center and history of a previous preterm birth. The primary endpoint was preterm birth before 33 weeks of gestation. Analysis was by intention to treat.*

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Results *Of 465 women randomized, seven were lost to follow-up and 458 (vaginal progesterone gel, n = 235; placebo, n = 223) were included in the analysis. Women allocated to receive vaginal progesterone had a lower rate of preterm birth before 33 weeks than did those allocated to placebo (8.9% (n = 21) vs 16.1% (n = 36); relative risk (RR), 0.55; 95% CI, 0.33–0.92; P = 0.02). The effect remained significant after adjustment for covariables (adjusted RR, 0.52; 95% CI, 0.31–0.91; P = 0.02). Vaginal progesterone was also associated with a significant reduction in the rate of preterm birth before 28 weeks (5.1% vs 10.3%; RR, 0.50; 95% CI, 0.25–0.97; P = 0.04) and 35 weeks (14.5% vs 23.3%; RR, 0.62; 95% CI, 0.42–0.92; P = 0.02), respiratory distress syndrome (3.0% vs 7.6%; RR, 0.39; 95% CI, 0.17–0.92; P = 0.03), any neonatal morbidity or mortality event (7.7% vs 13.5%; RR, 0.57; 95% CI, 0.33–0.99; P = 0.04) and birth weight < 1500 g (6.4% (15/234) vs 13.6% (30/220); RR, 0.47; 95% CI, 0.26–0.85; P = 0.01). There were no differences in the incidence of treatment-related adverse events between the groups.*

Conclusions *The administration of vaginal progesterone gel to women with a sonographic short cervix in the mid-trimester is associated with a 45% reduction in the rate of preterm birth before 33 weeks of gestation and with improved neonatal outcome. Copyright © 2011 ISUOG. Published by John Wiley & Sons, Ltd.*

INTRODUCTION

Preterm birth is the leading cause of perinatal morbidity and mortality, and its prevention is an important health-care priority[1]. In 2005, 12.9 million births worldwide were preterm[2]. A sonographic short cervix is a powerful predictor of preterm delivery[3–25], yet implementation of a screening program of all pregnant women requires the availability of a clinical intervention able to prevent preterm delivery and improve neonatal outcome[26]. Strategies that have been considered include progesterone administration[27], cervical cerclage[28–34] and insertion of a pessary[35].

A randomized clinical trial of vaginal progesterone capsules to prevent preterm delivery (< 34 weeks of gestation) in women with a short cervix (defined as 15 mm or less) reported a 44% reduction in the rate of preterm delivery (19.2% vs 34.4%; relative risk (RR), 0.56; 95% CI, 0.36–0.86), although this was not associated with a significant improvement in neonatal outcome[27]. In addition, secondary analyses of a randomized clinical trial[36] of vaginal progesterone in patients with a history of preterm birth showed that progesterone administration was associated with delayed cervical shortening[37] as pregnancy progressed, a lower rate of preterm birth, a lower frequency of admission to the neonatal intensive care unit (NICU) and a shorter length of NICU stay[38].

This study was undertaken to determine the efficacy and safety of vaginal progesterone gel in reducing the rate of preterm birth before 33 weeks in asymptomatic women with a mid-trimester sonographic short cervix.

METHODS

Study design and participants

This was a Phase-III, prospective, randomized, placebo-controlled, double-masked, parallel-group, multicenter, international trial. The study was conducted from March 2008 to November 2010 and was approved by the institutional review board of each participating center. Participants provided written informed consent to study coordinators or investigators prior to participation in the trial. Women between 19 + 0 and 23 + 6 weeks of gestation were eligible for screening. During the screening visit, cervical length and gestational age were determined. Women were eligible for the study if they met the following criteria: 1) singleton gestation; 2) gestational age between 19 + 0 and 23 + 6 weeks; 3) transvaginal sonographic cervical length between 10 and 20 mm; and 4) asymptomatic, i.e. without signs or symptoms of preterm labor. Subjects were allocated randomly to receive vaginal progesterone gel or placebo beginning at 20 to 23 + 6 weeks. Gestational age calculation was based on the participant's reported last menstrual period and fetal biometry[39].

Exclusion criteria included: 1) planned cerclage; 2) acute cervical dilation; 3) allergic reaction to progesterone; 4) current or recent progestogen treatment within the previous 4 weeks; 5) chronic medical conditions that would interfere with study participation or evaluation of the treatment (e.g. seizures, psychiatric disorders, uncontrolled chronic hypertension, congestive heart failure, chronic renal failure, uncontrolled diabetes mellitus with end-organ dysfunction, active thrombophlebitis or a thromboembolic disorder, history of hormone-associated thrombophlebitis or thromboembolic disorders, active liver dysfunction or disease, known or suspected malignancy of the breast or genital organs); 6) major fetal anomaly or known chromosomal abnormality; 7) uterine anatomic malformation (e.g. bicornuate uterus, septate uterus); 8) vaginal bleeding; or 9) known or suspected clinical chorioamnionitis.

All sonographers involved in sonographic cervical length measurements were required to participate in a training program and to obtain certification before screening patients for the trial. Moreover, the sonographic images of patients enrolled into the trial were reviewed by a central sonologist for quality assurance. An independent data coordinating center was responsible for randomization and data management. Clinical research monitors (Venn Life Sciences (St. Laurent, Quebec, Canada) and PharmOlam International (Houston, TX, USA)) conducted planned, regular site visits at each center, beginning with a site initiation visit and continuing until study completion, to independently assess compliance with the study protocol, timely collection of data, quality control, data completeness and data accuracy, according to International Conference on Harmonization (ICH) and Food and Drug Administration (FDA) Guidelines for Good Clinical Practice[40,41]. The study included 44 centers in 10 countries.

Randomization and masking

The randomization allocation was 1:1 (vaginal progesterone gel : placebo) and was accomplished using a centralized interactive voice response (IVR) system. Randomization was stratified according to: a) center and b) risk strata (previous preterm birth between 20 and 35 weeks or no previous preterm birth) using a permuted blocks strategy with a block size of four (i.e. two placebo and two vaginal progesterone gel). Contact with the IVR system required the input of subject characteristics and center number, after which the IVR system assigned a treatment for the specific subject based on the strata to which the subject belonged and the next assignment within the randomization block.

Allocation concealment was accomplished in three ways. First, subject drug kits at each study site were numbered independently from the treatment assignments in the randomization blocks to avoid identification of dispensing patterns. Second, the IVR system (upon generating a treatment assignment for a new subject) specified which kit number was to be dispensed to the subject. Third, the study drug packaging, applicators and their contents (vaginal progesterone and placebo) were identical in appearance.

Procedures

All of the drug required throughout the treatment interval for a randomized woman was included in drug kits to be assigned to each patient at each study visit in order to prevent dispensing errors. Prior to dispensing the assigned treatment, demographic, medical and obstetric history and physical examination data were collected from each participant. Treatment was to be initiated between 20 + 0 and 23 + 6 weeks' gestational age. Women self-administered the study drug once daily in the morning.

Study participants were instructed to return to the study center every 2 weeks. During each visit, subjects were interviewed to determine the occurrence of adverse events, use of concomitant medications and compliance with study drug. Women were asked to return unused study drug from the previous 2 weeks, and determination of compliance was based on the amount of study drug not used.

Study drug was continued until 36 + 6 weeks' gestational age, rupture of membranes or delivery, whichever occurred first. Both the vaginal progesterone gel (Prochieve® 8%, also known as Crinone® 8%) and placebo were supplied by Columbia Laboratories, Inc. (Livingston, NJ, USA) as a soft, white to off-white gel, in a single-use, one-piece, white disposable polyethylene vaginal applicator with a twist-off top. The progesterone and placebo gels were identical in appearance. Each applicator delivered 1.125 g gel containing 90 mg progesterone or placebo, and was wrapped and sealed in unmarked foil over-wrap. Both the active drug and the placebo were supplied in boxes of 14 applicators and were labeled with a unique kit number. Subjects received a 2-week supply at randomization and at each subsequent visit. They also received a 1-week emergency supply kit at the time of randomization and were resupplied during the treatment period if additional applicators were required before attending the next visit.

Patients who developed preterm labor during the study were treated according to the standard practice of the participating institutions, e.g. admission to the hospital, bed rest, intravenous fluids, tocolytic therapy, steroid administration, if clinically indicated. Administration of the study drug was to be continued during treatment for preterm labor, until delivery (in the absence of preterm rupture of membranes). Maternal and neonatal outcome were recorded throughout study participation and after delivery and discharge using a standardized electronic reporting template.

An emergency cerclage was allowed after randomization if the following criteria were met: 1) 21–26 weeks' gestational age; 2) cervical dilation > 2 cm; 3) membranes visible; 4) intact membranes; and 5) absence of uterine contractions, clinical chorioamnionitis and significant vaginal bleeding.

The primary outcome of this study was preterm birth before 33 weeks of gestation. The key secondary outcomes were neonatal morbidity, including respiratory distress syndrome (RDS), bronchopulmonary dysplasia, Grade III or IV intraventricular hemorrhage, periventricular leukomalacia, proven sepsis, necrotizing enterocolitis and perinatal mortality (fetal death or neonatal death). Four composite outcome scores were also used to assess perinatal mortality and neonatal morbidity (any event, two 0–4 scales and a 0–6 scale). The definitions for individual outcomes and composite scores are provided in the supplementary material online (Appendix S1). The outcome scores (0–4, 0–6) assigned ordinal values based upon the number of morbid events from 0 to 3 or 0 to 5; the highest number, 4 or 6, was assigned to a mortality event. For one of the 0–4 scores, number of NICU days was also used for assignment of the ordinal value. Other pre-specified secondary outcomes included preterm birth before 28, 35 and 37 weeks of gestation, neonatal length, weight and head circumference at birth and incidence of congenital abnormalities. The frequency of adverse events related to treatment was also assessed (see Appendix S2 online for definition of adverse events). All outcomes were determined and the database was locked prior to the unsealing of the randomization code.

Statistical analysis

We estimated that a sample size of 450 women (225 per treatment group) would have > 90% power (two-tailed alpha level of 0.05) to detect a 55% reduction in the rate of preterm birth before 33 weeks of gestation, from 22% in the placebo group to 9.9% in the vaginal progesterone group.

Analysis of the trial was conducted in three different analysis sets:

1) Intent-to-treat (ITT) analysis set: all patients randomized to either vaginal progesterone gel or placebo;

subjects without a documented delivery date were excluded;

2) Treated patient analysis set: patients who took at least one dose of either placebo or progesterone gel; women who received placebo and had no documented delivery date were considered as if they had delivered at term (37 weeks of gestation); for women who received vaginal progesterone gel and had no documented delivery date, the date of last contact was used as the delivery date;
3) Compliant analysis set: patients who used at least 80% of study medication, did not have a cerclage and were not lost to follow-up.

The primary endpoint of the study, preterm birth before 33 weeks, was analyzed using the Cochran–Mantel–Haenszel (CMH) test. The *P*-value was assessed at the two-sided significance level of 5%. Analysis of the primary efficacy endpoint was also performed using multivariable logistic regression, in which the following variables were included: treatment group, pooled study site, risk strata, gestational age at first dose, maternal age, cervical length, body mass index (BMI) and race. RR with 95% CI was used as the measure of effect. The CMH test was also used for the analysis of the ordinal composite scores described in Appendix S1 online. For this analysis, a modified ranking procedure (modified ridits) was used to calculate the sum of the expected values for each of the ordinal categories for each of the treatment groups. This ranking procedure is equivalent to non-parametric van Elteren scores. The RR for the primary endpoint was calculated unadjusted, partially adjusted (for pooled study site and risk strata) as well as fully adjusted using multivariable logistic regression. We also calculated the number needed to treat[42], with 95% CIs for the primary outcome and the most common complication of preterm birth, RDS. All analyses were performed with SAS® 9.2 (SAS Institute Inc., Cary, NC, USA) on a Windows 2003 operating system.

An independent Data and Safety Monitoring Board (DSMB) reviewed unblinded data relevant to safety (not efficacy) after approximately 50% of the subjects had delivered. The observed frequency of adverse events did not exceed that expected or that stated in the informed consent. The DSMB recommended the study continue without modification of the protocol or informed consent. This trial is registered with ClinicalTrials.gov, number NCT00615550.

RESULTS

Of the 32 091 women who underwent sonographic measurement of cervical length between 19 + 0 and 23 + 6 weeks of gestation, 2.3% (733/32 091) were reported to have a cervical length of 10–20 mm. Four hundred and sixty-five women agreed to participate and were randomized, of whom seven were lost to follow-up (vaginal progesterone gel, $n = 1$; placebo $n = 6$). Thus, 458 women were included in the ITT analysis set (vaginal progesterone gel, $n = 235$; placebo, $n = 223$). Figure 1 shows the participant flow diagram (see Appendix S3 online for further details regarding patient disposition). The trial ended on the delivery date of the last delivered participant. Of the 458 women, 16% ($n = 72$) had a history of a previous preterm birth between 20 and 35 weeks of gestation.

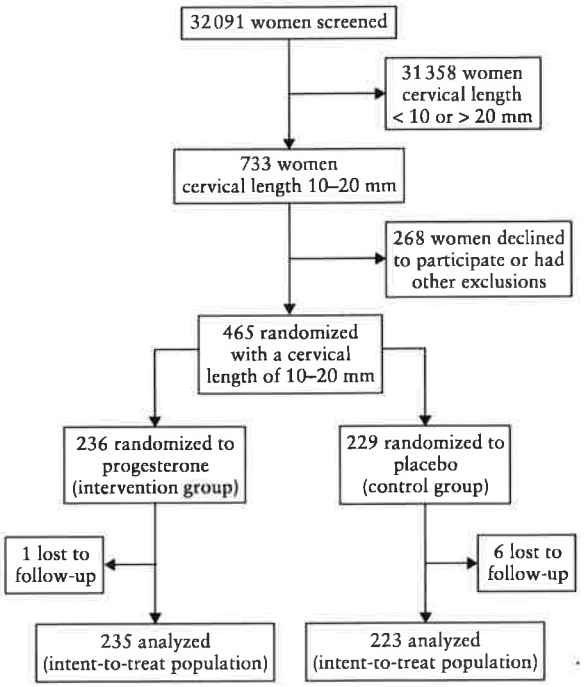

Figure 1 Participant flow diagram.

Baseline maternal characteristics were similar between the placebo and the vaginal progesterone groups (Table 1). There were no differences between the two groups in median duration of treatment (14.3 weeks for vaginal progesterone gel and 13.9 weeks for placebo) or mean study drug administration compliance reported by the investigator (93.3% (SD, ± 13.1%) for vaginal progesterone gel and 94.0% (SD, ± 12.7%) for placebo). A history of cervical surgery was present in 9.4% (22/235) of patients allocated to receive vaginal progesterone gel and in 12.6% (28/223) of those allocated to the placebo group ($P = 0.20$). Sixteen women (10 in the vaginal progesterone group and six in the placebo group; $P = 0.46$) underwent an emergency cervical cerclage after randomization.

Patients allocated to receive vaginal progesterone gel had a significantly lower rate of preterm birth before 33 weeks of gestation compared with those allocated to placebo (8.9% ($n = 21$) vs 16.1% ($n = 36$); RR, 0.55; 95% CI, 0.33–0.92; $P = 0.02$; adjusted (pooled study site and risk strata) RR, 0.54; 95% CI, 0.33–0.89; $P = 0.01$). Fourteen women with cervical length between 10 and 20 mm would need to be treated with vaginal progesterone gel to prevent one case of preterm birth before 33 weeks of gestation (95% CI, 8–87). Even after

Table 1 Baseline and treatment characteristics of 458 asymptomatic women with a singleton pregnancy and sonographic short cervix randomized to receive vaginal progesterone gel or placebo

Characteristic	*Vaginal progesterone (n = 235)*	*Placebo (n = 223)*
Age (years)		
Median (range)	25.3 (18–44)	25.6 (18–41)
Interquartile range	(21.8–30.3)	(21.9–29.4)
Mean (SD)	26.5 (5.8)	26.2 (5.1)
Race (*n* (%))		
African-American	76 (32)	67 (30)
Asian	76 (32)	74 (33)
Caucasian	73 (31)	70 (31)
Other	10 (4)	12 (5)
Body mass index (kg/m^2)		
Median (range)	24.5 (14–47)	23.6 (14–50)
Interquartile range	(20.4–30.0)	(20.5–29.2)
Mean (SD)	25.6 (6.3)	25.3 (6.8)
Obstetric history (*n* (%))		
Nulliparous	125 (53)	126 (57)
No previous PTD*	204 (87)	195 (87)
≥ 1 previous PTD*	31 (13)	28 (13)
Cervical length (mm)		
Median (range)	18 (10–21)	18 (10–20)
Interquartile range	(16–19)	(15–19)
Mean (SD)	17 (2.5)	17 (2.8)
GA at first dose of progesterone (weeks)		
Median (range)	21.7 (19–25)	21.7 (17–25)
Interquartile range	(20.7–23.0)	(20.4–22.9)
Mean (SD)	21.9 (1.4)	21.7 (1.4)
Duration of treatment (weeks)		
Median (range)	14.3 (0–18)	13.9 (0–18)
Interquartile range	(12.6–15.7)	(10.9–15.7)
Mean (SD)	13.0 (4.2)	12.5 (4.7)
†Compliance (%)		
Median (range)	99.2 (6–100)	100 (0–100)
Interquartile range	(92.7–100)	(93.0–100)
Mean (SD)	93.3 (13.1)	94.0 (12.7)

*Preterm delivery (PTD) > 20 weeks and < 32 weeks. †Reported compliance was calculated using the following formula: (Number of vaginal applicators used since last visit/Number of vaginal applicators that should have been used since last visit) × 100. Every 2 weeks, a percentage of compliance was calculated and the compliance for a specific patient was based on the average of all visits. The definition of compliance was based on the formula and percentage indicated above, and a compliant patient was defined as one with an average of > 80% compliance. GA, gestational age.

adjustment for pooled study site, risk strata, treatment group, gestational age at first dose, maternal age, cervical length, BMI and race using multivariable logistic regression analysis, the effect of vaginal progesterone gel remained significant for the primary endpoint (adjusted RR, 0.52; 95% CI, 0.31–0.91; $P = 0.02$). No interaction between treatment and pooled study site was detected ($P = 0.2$). In women without a history of preterm birth (84% of the population), vaginal progesterone gel administration was associated with a significant reduction in the rate of preterm birth before 33 weeks (7.6% (15/197) vs 15.3% (29/189); RR, 0.50; 95% CI, 0.27–0.90; $P = 0.02$). However, the reduction in the rate of preterm birth in women with a prior history of preterm birth between 20 and 35 weeks of gestation did not reach statistical significance (15.8% (6/38) vs 20.6% (7/34); RR, 0.77; 95% CI, 0.29–2.06; $P = 0.60$).

Vaginal progesterone gel was also associated with a significant reduction in the rate of preterm birth before 35 weeks (14.5% ($n = 34$) vs 23.3% ($n = 52$); RR, 0.62; 95% CI, 0.42–0.92; $P = 0.02$) and before 28 weeks of gestation (5.1% ($n = 12$) vs 10.3% ($n = 23$); RR, 0.50; 95% CI, 0.25–0.97; $P = 0.04$). Figure 2 displays the survival analysis for patients in the entire ITT analysis set (Figure 2a), patients with no prior preterm delivery (Figure 2b) and patients with a prior preterm delivery (Figure 2c). The curves demonstrate a separation between patients allocated to receive vaginal progesterone gel and those in the placebo group. However, there was no difference in the proportion of patients who delivered at < 37 weeks, because the curves converge and overlap at this point. One interpretation of this is that the administration of vaginal progesterone shifted the proportion of patients who would have delivered very preterm to a later gestational age. In addition, vaginal progesterone was associated with a significant reduction in the rate of neonatal birth weight < 1500 g (6.4% (15/234) vs 13.6% (30/220); RR, 0.47; 95% CI, 0.26–0.85; $P = 0.01$) (Table 2).

In terms of infant outcome, neonates born to women allocated to receive vaginal progesterone gel had a significantly lower frequency of RDS than did those born to women allocated to receive placebo (3.0% ($n = 7$) vs 7.6% ($n = 17$); RR, 0.39; 95% CI, 0.17–0.92; $P = 0.03$). The number needed to treat for benefit was 22 (95% CI, 12–186). This effect remained significant after adjustment for pooled study site and risk strata (RR, 0.40; 95% CI, 0.17–0.94; $P = 0.03$). The other neonatal outcomes are listed in Table 2. Pre-specified composite scores to assess perinatal mortality/neonatal morbidity were calculated. The rate of any morbidity or mortality was significantly lower in the neonates of subjects allocated to receive vaginal progesterone gel compared with those allocated to receive placebo (7.7% ($n = 18$) vs 13.5% ($n = 30$); RR, 0.57; 95% CI, 0.33–0.99; $P = 0.04$). The composite scores '0–4 scale without NICU' and '0–6 scale without NICU' were also significantly lower in the progesterone gel group compared with the placebo group ($P < 0.05$ for both comparisons). After adjustment for pooled study site and risk strata, the effect of vaginal progesterone gel on composite perinatal mortality/neonatal morbidity scores 'any morbidity/mortality event', '0–4 scale without NICU' and '0–6 scale without NICU' continued to show trends toward improvement ($P = 0.054$, 0.065 and 0.065, respectively). The frequency of distributions for the perinatal mortality/neonatal morbidity composite scores can be found in Appendix S4 online.

Adverse events were comparable between patients who received vaginal progesterone gel and those who received placebo. The rate of adverse events related to study treatment was not significantly different in women who received vaginal progesterone gel compared with

those who received placebo (12.8% ($n = 30$) vs 10.8% ($n = 24$); RR, 1.19; 95% CI, 0.72–1.96; $P = 0.51$); the most frequently reported adverse events related to study treatment occurred in up to 2% of women and included vaginal pruritus, vaginal discharge, vaginal candidiasis and nausea. Furthermore, no fetal or neonatal safety signal[43] was detected for vaginal progesterone gel. Regarding labor and delivery data, there were no meaningful differences in method of delivery. There was one case of a congenital anomaly in the vaginal progesterone group and there were three in the placebo group (RR, 0.32; 95% CI, 0.03–3.02; $P = 0.29$). Median 1-min and 5-min Apgar scores were comparable between study groups.

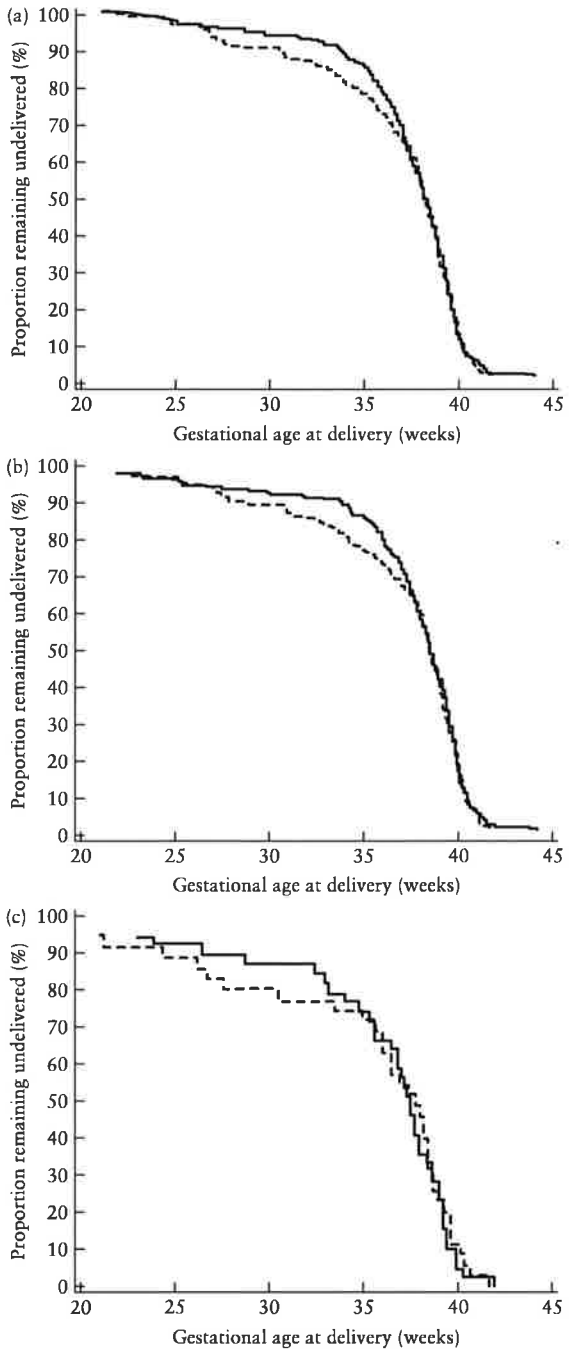

Figure 2 Survival analysis of intent-to-treat analysis set showing proportion of patients remaining undelivered according to treatment allocation: vaginal progesterone (———) vs placebo (- - - -). (a) Entire population (patients with and without a prior history of preterm delivery) (vaginal progesterone $n = 235$, placebo $n = 223$); (b) patients without a prior history of preterm delivery (vaginal progesterone $n = 197$, placebo $n = 189$); (c) patients with a prior history of preterm delivery (vaginal progesterone $n = 38$, placebo $n = 34$). $P > 0.05$ for all comparisons.

Treated patient analysis set

Of the 465 women who were randomized, 459 women received at least one dose of study drug (vaginal progesterone gel, $n = 235$; placebo, $n = 224$) and represent the 'treated patient analysis set'. Of these, 16% ($n = 71$) of the women had a history of a previous preterm birth between 20 and 35 weeks of gestation.

There were no differences between the two groups in the baseline patient characteristics, median duration of treatment (14.3 weeks for vaginal progesterone gel and 13.9 weeks for placebo) or mean study drug administration compliance reported by the investigator (93.3% (SD, ±13.1%) for vaginal progesterone gel and 94.5% (SD, ±10.9%) for placebo). Table 3 displays results of primary and secondary outcomes.

After adjustment for study site and risk strata (history of preterm birth), the effect of vaginal progesterone gel remained significant for the reduction in the primary endpoint of the rate of preterm birth before 33 weeks of gestation (8.9% (21/235) vs 15.2% (34/224); RR, 0.56; 95% CI, 0.33–0.93; $P = 0.02$) as well as the rate of RDS (3.0% (7/235) vs 7.1% (16/224); RR, 0.42; 95% CI, 0.18–0.97; $P = 0.04$). Pre-specified composite scores to assess perinatal mortality/neonatal morbidity were calculated: 0–4 scale without NICU, 0–4 scale with NICU and 0–6 scale without NICU ($P = 0.113$, 0.103 and 0.113, respectively, for vaginal progesterone gel vs placebo).

Adverse events were comparable between patients who received vaginal progesterone gel and those who received placebo. The rate of adverse events related to study treatment was not significantly different in women who received vaginal progesterone gel compared to those who received placebo (12.8% (30/235) vs 10.7% (24/224); RR, 1.14; 95% CI, 0.72–1.80; $P = 0.59$); the most frequently reported adverse events related to study treatment occurred in up to 2% of women and included vaginal pruritus, vaginal discharge, vaginal candidiasis and nausea. Furthermore, no fetal or neonatal safety signal was detected for vaginal progesterone gel. Regarding labor and delivery data, there were no differences in the method of delivery. There was one case of a congenital anomaly in the vaginal progesterone gel group and there were three in the placebo group. Median 1-min and 5-min Apgar scores were comparable between the groups. Women allocated to receive vaginal progesterone gel had a lower rate of neonates born weighing < 1500 g compared with those

Table 2 Gestational age at delivery and neonatal outcome in asymptomatic women with a singleton pregnancy and sonographic short cervix allocated to receive vaginal progesterone gel ($n = 235$) compared with those allocated to receive placebo ($n = 223$): intent to treat analysis set

Outcome	*Vaginal progesterone (n (%))*	*Placebo (n (%))*	*Relative risk (95% CI)*	P
Primary outcome				
Preterm birth < 33 weeks	21/235 (8.9)	36/223 (16.1)	0.55 (0.33–0.92)	0.020
Secondary outcomes				
Preterm birth < 28 weeks	12/235 (5.1)	23/223 (10.3)	0.50 (0.25–0.97)	0.036
Preterm birth < 35 weeks	34/235 (14.5)	52/223 (23.3)	0.62 (0.42–0.92)	0.016
Preterm birth < 37 weeks	71/235 (30.2)	76/223 (34.1)	0.89 (0.68–1.16)	0.376
Respiratory distress syndrome	7/235 (3.0)	17/223 (7.6)	0.39 (0.17–0.92)	0.026
Bronchopulmonary dysplasia	4/235 (1.7)	5/223 (2.2)	0.76 (0.21–2.79)	0.678
Proven sepsis	7/235 (3.0)	6/223 (2.7)	1.11 (0.38–3.24)	0.853
Necrotizing enterocolitis	5/235 (2.1)	4/223 (1.8)	1.19 (0.32–4.36)	0.797
Intraventricular hemorrhage, Grade III/IV	0/235 (0.0)	1/223 (0.5)	0.32 (0.01–7.73)*	0.305
Periventricular leukomalacia	0/235 (0.0)	0/223 (0.0)	Not estimable	NA
Perinatal death	8/235 (3.4)	11/223 (4.9)	0.69 (0.28–1.68)	0.413
Fetal death	5/235 (2.1)	6/223 (2.7)	0.79 (0.25–2.57)	0.700
Neonatal death	3/235 (1.3)	5/223 (2.2)	0.57 (0.14–2.35)	0.431
Composite outcome scores				
Any morbidity/mortality event	18/235 (7.7)	30/223 (13.5)	0.57 (0.33–0.99)	0.043
0–4 without NICU†				0.048
0–4 with NICU†				0.068
0–6 without NICU†				0.048
Birth weight < 2500 g	60/234 (25.6)	68/220 (30.9)	0.83 (0.62–1.11)	0.213
Birth weight < 1500 g	15/234 (6.4)	30/220 (13.6)	0.47 (0.26–0.85)	0.010

Unadjusted relative risk (RR) and 95% CI calculated using the Cochran–Mantel–Haenszel (CMH) test. *Based on Logit estimator with continuity correction. †Frequency of perinatal mortality/neonatal morbidity composite scores are provided in Appendix S4 online. NA, not applicable; NICU, neonatal intensive care unit.

in the placebo group (6.4% (15/234) vs 13.3% (29/218); RR, 0.49; 95% CI, 0.27–0.88; $P = 0.01$).

Compliant analysis set

A pre-specified analysis was conducted in a subgroup (84%, 387/459; vaginal progesterone gel, $n = 194$; placebo, $n = 193$) of the treated patient analysis set, excluding those who had < 80% treatment compliance ($n = 53$), those who did not have a documented delivery date ($n = 4$), or who had a cerclage ($n = 17$). One subject had < 80% compliance and a cerclage and one subject had no delivery date and a cerclage.

This compliant analysis set showed for unadjusted analyses that patients allocated to vaginal progesterone gel had a significantly lower frequency of preterm birth than did those allocated to placebo for delivery < 28 weeks of gestation (3.1% (6/194) vs 7.8% (15/193); RR, 0.40; 95% CI, 0.16–1.00; $P = 0.04$), delivery < 33 weeks of gestation (5.7% (11/194) vs 13.0% (25/193); RR, 0.44; 95% CI, 0.22–0.86; $P = 0.01$) and delivery < 35 weeks of gestation (10.3% (20/194) vs 20.2% (39/193); RR, 0.51; 95% CI, 0.31–0.84; $P < 0.01$). There was no significant difference in the rate of preterm delivery before 37 weeks of gestation (26.8% (52/194) vs 30.6% (59/193); RR, 0.88; 95% CI, 0.64–1.20; $P = 0.41$). Table 4 displays results of primary outcome and secondary outcomes, RDS and any morbidity/mortality event.

After adjustment for study site and risk strata, the effect of vaginal progesterone gel remained significant for the reduction in the primary endpoint – the rate of preterm birth before 33 weeks of gestation (RR, 0.42; 95% CI, 0.22–0.82; $P < 0.01$) and preterm birth before 35 weeks of gestation (RR, 0.50; 95% CI, 0.31–0.82; $P < 0.01$). Pre-specified composite scores to assess perinatal mortality/neonatal morbidity (0–4 scale without NICU, 0–4 scale with NICU and 0–6 scale without NICU) showed trends towards significance ($P = 0.058$, 0.049 and 0.058, respectively).

In summary, there was no evidence of a safety signal, and the evidence for the efficacy of vaginal progesterone gel was demonstrated in a similar manner for both of these additional analysis sets to that demonstrated for the intent-to-treat analysis set.

DISCUSSION

Principal findings of the study

Administration of vaginal progesterone gel to women with a short cervix (10–20 mm) was associated with: 1) a substantial reduction in the rate of preterm delivery < 33 weeks (primary endpoint), < 35 weeks and < 28 weeks of gestation; 2) a significant decrease in the rate of RDS; 3) a similar rate of treatment-related adverse events in patients allocated to progesterone or placebo gel; and 4) no evidence of a 'safety signal'.

Clinical implications of the study

The prevention of preterm birth is a major healthcare priority. The ultimate purpose of interventions designed

Table 3 Gestational age at delivery and neonatal outcome in asymptomatic women with a singleton pregnancy and sonographic short cervix allocated to receive vaginal progesterone gel ($n = 235$) compared with those allocated to receive placebo ($n = 224$): treated patient analysis set

Outcome	*Vaginal progesterone (n (%))*	*Placebo (n (%))*	*Unadjusted RR (95% CI)**	P*	*Adjusted RR (95% CI)†*	P†
Primary outcome						
Preterm birth < 33 weeks	21 (8.9)	34 (15.2)	0.59 (0.35–0.98)	0.040	0.56 (0.33–0.93)	0.022
Secondary outcomes						
Preterm birth < 28 weeks	12 (5.1)	21 (9.4)	0.54 (0.27–1.08)	0.077	0.55 (0.28–1.08)	0.075
Preterm birth < 35 weeks	34 (14.5)	50 (22.3)	0.65 (0.44–0.96)	0.030	0.61 (0.41–0.90)	0.012
Preterm birth < 37 weeks	71 (30.2)	74 (33.0)	0.91 (0.70–1.20)	0.516	0.89 (0.68–1.15)	0.377
RDS	7 (3.0)	16 (7.1)	0.42 (0.17–0.99)	0.041	0.42 (0.18–0.97)	0.036
BPD	4 (1.7)	5 (2.2)	0.77 (0.21–2.80)	0.683	0.78 (0.21–2.83)	0.701
Proven sepsis	7 (3.0)	5 (2.2)	1.33 (0.43–4.14)	0.617	1.37 (0.45–4.17)	0.577
NEC	5 (2.1)	4 (1.8)	1.19 (0.32–4.38)	0.792	1.21 (0.34–4.30)	0.769
IVH Grade III/IV	0	1 (0.5)	0.32 (0.01–7.76)‡	0.306	0.32 (0.01–7.48)‡	0.307
PVL	0	0	Not estimable	NA	Not estimable	NA
Perinatal death	8 (3.4)	10 (4.5)	0.76 (0.31–1.90)	0.559	0.78 (0.31–1.97)	0.596
Neonatal death	3 (1.3)	5 (2.2)	0.57 (0.14–2.37)	0.435	0.57 (0.14–2.36)	0.436
Any morbidity/mortality event	18 (7.7)	28 (12.5)	0.61 (0.35–1.08)	0.085	0.62 (0.36–1.08)	0.088
Birth weight < 2500 g	60/234 (25.6)	67/218 (30.7)	0.83 (0.62–1.12)	0.229	0.83 (0.62–1.11)	0.204
Birth weight < 1500 g	15/234 (6.4)	29/218 (13.3)	0.48 (0.27–0.87)	0.014	0.49 (0.27–0.88)	0.014

*Unadjusted relative risk (RR) and 95% CI calculated using the Cochran–Mantel–Haenszel (CMH) method; *P*-value based on CMH test. †RR and 95% CI calculated using the CMH method adjusted for pooled study site and risk strata; *P*-value based on CMH test adjusted for pooled study site and risk strata. ‡Based on Logit estimator with continuity correction. BPD, bronchopulmonary dysplasia; GA, gestational age; IVH, intraventricular hemorrhage; NA, not applicable; NEC, necrotizing enterocolitis; PVL, periventricular leukomalacia; RDS, respiratory distress syndrome.

Table 4 Gestational age at delivery and neonatal outcome in asymptomatic women with a singleton pregnancy and sonographic short cervix allocated to receive vaginal progesterone gel ($n = 194$) compared with those allocated to receive placebo ($n = 193$): compliant analysis set

Outcome	*Vaginal progesterone (n (%))*	*Placebo (n (%))*	*Unadjusted RR (95% CI)**	P*	*Adjusted RR (95% CI)†*	P†
Primary outcome						
Preterm birth < 33 weeks	11 (5.7)	25 (13.0)	0.44 (0.22–0.86)	0.014	0.42 (0.22–0.82)	0.009
Secondary outcomes						
Preterm birth < 28 weeks	6 (3.1)	15 (7.8)	0.40 (0.16–1.00)	0.043	0.40 (0.16–1.03)	0.048
Preterm birth < 35 weeks	20 (10.3)	39 (20.2)	0.51 (0.31–0.84)	0.007	0.50 (0.31–0.82)	0.005
Preterm birth < 37 weeks	52 (26.8)	59 (30.6)	0.88 (0.64–1.20)	0.413	0.85 (0.62–1.17)	0.326
RDS	7 (3.6)	14 (7.3)	0.50 (0.21–1.21)	0.114	0.48 (0.19–1.17)	0.098
BPD	3 (1.6)	4 (2.1)	0.75 (0.17–3.29)	0.698	0.85 (0.18–3.90)	0.832
Proven sepsis	6 (3.1)	5 (2.6)	1.19 (0.37–3.85)	0.767	1.18 (0.35–3.92)	0.789
NEC	4 (2.1)	3 (1.6)	1.33 (0.30–5.85)	0.708	1.41 (0.34–5.80)	0.634
IVH Grade III/IV	0	1 (0.5)	0.33 (0.01–8.09)‡	0.316	0.39 (0.02–8.93)‡	0.355
PVL	0	0	Not estimable	NA	Not estimable	NA
Perinatal death	3 (1.6)	6 (3.1)	0.50 (0.13–1.96)	0.309	0.43 (0.10–1.90)	0.248
Neonatal death	2 (1.0)	3 (1.6)	0.66 (0.11–3.93)	0.649	0.70 (0.12–4.18)	0.697
Any morbidity/mortality event	11 (5.7)	21 (10.9)	0.52 (0.26–1.05)	0.063	0.50 (0.24–1.03)	0.053
Birth weight < 2500 g	45 (23.2)	54/192 (28.1)	0.82 (0.59–1.16)	0.268	0.80 (0.57–1.13)	0.210
Birth weight < 1500 g	8 (4.1)	22/192 (11.5)	0.36 (0.16–0.79)	0.007	0.37 (0.17–0.80)	0.008

*Unadjusted relative risk (RR) and 95% CI calculated using the Cochran–Mantel–Haenszel (CMH) method; *P*-value based on CMH test. †RR and 95% CI calculated using the CMH method adjusted for pooled study site and risk strata; *P*-value based on CMH test adjusted for pooled study site and risk strata. ‡Based on Logit estimator with continuity correction. BPD, bronchopulmonary dysplasia; GA, gestational age; IVH, intraventricular hemorrhage; NA, not applicable; NEC, necrotizing enterocolitis; PVL, periventricular leukomalacia; RDS, respiratory distress syndrome.

to reduce preterm birth is improvement in infant outcome. To date, no intervention in an asymptomatic patient with a risk factor has demonstrated both a reduction in preterm birth and an improvement in infant outcome, without a safety signal[44]. The results of this trial indicate that a combined approach, in which transvaginal sonographic cervical length is used to identify patients at risk for preterm delivery, followed by the administration of vaginal progesterone gel from the mid-trimester of pregnancy until term, reduces the rate of both preterm birth before 33 weeks of gestation and RDS, the most common complication of preterm neonates. In addition to the primary and secondary endpoints related to gestational age, administration of vaginal progesterone

gel was associated with a significant reduction in the proportion of infants with any morbidity/mortality event, and a significant improvement in neonatal outcome was demonstrated through two additional composite scores as well as a significant reduction in birth weight < 1500 g. Of note, vaginal progesterone gel was well-tolerated and compliance was substantial (> 90%).

Results in the context of other studies

The primary result of this trial is similar to that reported by Fonseca *et al.*[27], who found that vaginal progesterone (200 mg vaginal capsules) administered to women with a cervical length ≤ 15 mm at a median gestational age of 23 weeks reduced the rate of spontaneous preterm (< 34 weeks) delivery by 44%. In our trial, there was a 45% reduction in the rate of preterm delivery before 33 weeks. This finding is robust because it was supported by a significant 38% reduction in the rate of preterm birth < 35 weeks, a 50% reduction at < 28 weeks, and a 53% reduction in the rate of birth weight < 1500 g. In addition, the reduction in preterm birth observed in this trial translated into the improvement of clinically important neonatal outcomes such as RDS and three composite perinatal mortality/neonatal morbidity scores.

Both the study by Fonseca *et al.*[27] and the current trial used a similar approach to identify the patients at risk, namely, screening with transvaginal sonography to diagnose a short cervix. Differences between the trials are that: 1) our study excluded twin gestations, which have not been shown to benefit from the prophylactic administration of progesterone[45] or 17 alpha-hydroxyprogesterone caproate[46,47]; 2) the cervical length for entry into our study was 10–20 mm. Patients with a cervical length of 10 mm or less have a higher rate of intra-amniotic infection/inflammation[48] and are less likely to benefit from progesterone administration than are patients with a longer cervix. We extended the upper limit of cervical length to 20 mm to explore whether vaginal progesterone gel would have a beneficial effect beyond 15 mm and therefore expand its therapeutic range; 3) the treatment protocol in our study called for initiation of vaginal progesterone as early as 20 weeks of gestation, continuing until 36 + 6 weeks, while Fonseca *et al.*[27] began at 24 weeks and stopped at 34 weeks (it is possible that earlier treatment may confer more beneficial effects); and 4) the formulation of vaginal progesterone was different. Fonseca *et al.*[27] used oil capsules containing 200 mg progesterone, while we employed a bioadhesive gel with 90 mg progesterone. The vaginal gel preparation has been shown to be biologically active in supporting pregnancies in the first trimester undergoing assisted reproductive technology and, despite the lower dose of progesterone, our current trial results indicate that the dose was sufficient to reduce the rate of preterm delivery. We postulate that this is attributable to the bioadhesive nature of the preparation, which may enhance bioavailability.

Strengths and limitations of the study

The strengths of this study are that it was a multicenter, placebo-controlled, double-masked, randomized trial with rigorous standards for the allocation of treatment and concealment of the identity of the treatment. The placebo and vaginal progesterone gel preparations were identical in appearance and procedures were in place to reduce the risk of other biases. We also performed an additional sensitivity analysis in the ITT analysis set to provide a 'worst-case' scenario, in which women lost to follow-up who received vaginal progesterone were considered as if they had a preterm birth before 33 weeks of gestation whereas women lost to follow-up who received placebo were considered as if they had a term delivery (≥ 37 weeks of gestation). Even in this worst-case scenario of the ITT analysis set, the beneficial effect of vaginal progesterone on the rate of preterm birth before 33 weeks of gestation remained significant (9.3% (22/236) vs 15.7% (36/229); RR, 0.59; 95% CI, 0.36–0.98; $P = 0.04$).

Another strength of this study is its apparent external validity, supported by the following: 1) our primary results were consistent with those of a similar trial[27] that tested the effects of vaginal progesterone capsules in women with a short cervix and reported a similar effect size; 2) the preterm delivery rate in the placebo arm was similar to that reported in studies in the literature[12,17,49]; 3) there was no treatment by site interaction albeit with the necessity to pool sites for this test; and 4) the multinational nature of the trial, in which there was substantial representation (approximately 30%) for each of the following ethnic groups: African-American, Asian and Caucasian.

A limitation of the study is that the primary endpoint is a surrogate for infant outcome. The use of surrogate endpoints is common in clinical trials because of the pragmatic challenges in the execution of trials when infant outcome is the primary outcome of interest. Our study was not powered to detect differences in the outcome according to risk strata (presence or absence of a previous preterm birth).

Sonographic cervical length to identify the patient at risk for preterm delivery

It is now well-established that the shorter the sonographic cervical length in the mid-trimester, the higher the risk of preterm delivery[12,14–23,25]. Indeed, it is possible to assign an individualized risk[50] for preterm delivery using sonographic cervical length and other maternal risk factors, such as maternal age, ethnic group, BMI and previous cervical surgery. Among these factors, sonographic cervical length is the most powerful predictor for preterm birth in the index pregnancy, and is more informative than is a history of previous preterm birth[14,17]. Selecting patients for prophylactic administration of progestogens based only on a history of a previous preterm birth[36,51–53] would have an effect

(albeit limited) on the prevention of preterm delivery worldwide, because most women who deliver preterm neonates do not have this history. Moreover, such strategy cannot be implemented in nulliparous women; therefore, universal risk assessment (primigravidae and parous women) is possible with transvaginal cervical ultrasound. A pharmacoeconomic study is in progress to address the issue of cost-effectiveness, based on the observations of this study.

The effect of progesterone on the uterine cervix

Although the original focus of the effect of progesterone in pregnancy maintenance was on the myometrium[54–63], it is now clear that this hormone exerts biological effects on the chorioamniotic membranes[64–67] and the uterine cervix[68–96]. Indeed, progesterone is considered key in the control of cervical ripening[70–78,80–84,86,87,89,91,92,94–96]. The precise mechanism by which progesterone prevents preterm delivery in women with a short cervix has not been established. A local effect is likely, given the high concentrations of circulating progesterone in pregnant women[97,98].

Differences among progestogens

The term 'progestogen', like 'progestin', includes both natural progesterone and synthetic compounds with progesterone-like actions. The compound used in this study is identical to natural progesterone, as was the case in the study by Fonseca *et al.*[27]. Progesterone is currently approved to support pregnancies in the first trimester in patients undergoing assisted reproductive technologies in the United States[99], Europe and other countries. The safety profile of the preparation used in this study is well-established. In contrast, there are no data to date to support the use of 17-alpha hydroxyprogesterone caproate, a synthetic progestogen, to prevent preterm birth in women with a sonographic short cervix.

Future studies

Additional studies are necessary to determine if treatment of women with a short cervix in the early second trimester may further reduce the rate of preterm delivery[100]. Moreover, it is important to determine if women with twin gestations who have a short cervix may also benefit from vaginal progesterone. The previous negative results of a randomized clinical trial in twin gestations could be attributed to the inclusion of patients with a long cervix who thus may not have benefited from vaginal progesterone. The optimal treatment of patients with a cervical length < 10 mm remains a challenge. Similarly, whether vaginal progesterone may modify the effect of vaginal cerclage remains to be determined.

Importance of the findings

The potential impact of this intervention in clinical practice can be surmised from the estimate that 14 patients need to be treated to prevent one preterm birth before 33 weeks of gestation. Moreover, 22 patients need to be treated to prevent one episode of RDS. These figures compare well with those of two interventions used widely in obstetrics; 100 patients with pre-eclampsia need to be treated with magnesium sulfate to prevent one case of eclampsia[101] and 13 women at high risk of preterm birth need to receive antenatal corticosteroids to prevent one case of RDS[102].

Implications for clinical practice

The main implication of this study for clinical practice is that universal screening of women with transvaginal sonography to measure cervical length in the mid-trimester to identify patients at risk can now be coupled with an intervention – the administration of vaginal progesterone gel – to reduce the frequency of preterm birth and improve neonatal outcome.

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Contributors

S.S.H., R.R., D.V., S.F., J.K.B., M.K., J.V., Y.T., P.S.P., P.S., A.D., V.P., J.O., V.A., O.Y., W.K., B.D., H.S., L.M., D.M., M.T.G. and G.W.C. contributed to the conception, design, management and interpretation of data, drafting and critically revising the manuscript for important intellectual content, and approving the final version to be published. J.A.P., L.S. and A.C.A. contributed to data analysis and interpretation, as well as drafting and critically revising the manuscript for important intellectual content, and approving the final version to be published. L.S. and A.C.A. were funded exclusively by NICHD/NIH and not Columbia Laboratories, Inc.

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The authors were responsible for the study design, data collection and interpretation of the results of the data analysis. The Perinatology Research Branch of the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD)/National Institutes of Health (NIH) was responsible for the writing of the report and the decision to submit the paper for publication. The funding sources (NICHD/NIH and Columbia Laboratories, Inc.) were not involved in writing the report or the decision to submit the paper for publication.

CONFLICTS OF INTEREST

S.S.H., R.R., M.T.G., A.C.A., W.K. and L.S. have no financial interest. Author-investigators D.V., S.F., J.B., M.K., J.V., Y.T., P.S.-P., P.S., A.D., V.P., J.O.'B., V.A., O.Y., B.D., H.S., L.M. and D.M. conducted this study with the support of grants awarded by Columbia Laboratories, Inc. for the specific purpose of conducting this trial. The terms and conditions for the awarding of the grants were consistent with those which are customary for this type of industry-sponsored trial and all payments were independent of the outcome of the trial. In addition, J.K.B. and J.O.'B. have also received consulting fees and travel expenses related to Preterm Birth Advisory Committee meetings related to the project. J.O.'B. is an inventor on a patent for the use of progesterone in the prevention of preterm birth. J.A.P. received remuneration as a statistical consultant to Columbia Laboratories, Inc. G.W.C. is an employee of Columbia Laboratories, Inc.

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SUPPORTING INFORMATION ON THE INTERNET

The following supporting information, provided by the authors, may be found in the online version of this article:

Appendix S1 Definitions of neonatal morbidity/mortality and definitions of composite perinatal mortality/neonatal morbidity outcome scores.

Appendix S2 Definition of adverse events.

Appendix S3 Trial profile.

Appendix S4 Frequency distributions for perinatal mortality/neonatal morbidity composite scores: intention-to-treat analysis set.

This article has been selected for Journal Club.

A slide presentation, prepared by Dr Asma Khalil, one of UOG's Editors for Trainees, is available online.

Supplementary Material

Appendix S1 Definitions of Neonatal Morbidity/Mortality*[1,2]

Intraventricular Hemorrhage[3,4] (as determined by cranial ultrasound or CT)

Grade I – subependymal hemorrhage

Grade II – intraventricular hemorrhage, uncomplicated

Grade III – intraventricular hemorrhage with ventricular dilatation

Grade IV – intraventricular hemorrhage with ventricular dilatation and parenchymal extension

Necrotizing Enterocolitis[5]

Surgical – Stage III – Advanced

- Treatment was surgical

Other findings may include:

- perinatal stress
- systemic manifestations such as temperature instability, lethargy, apnea, bradycardia, occult or gross GI bleeding, abdominal distension, plus septic shock
- radiographs show: intestinal distension with ileus, small bowel separation, rigid bowel loops, pneumatosis intestinalis, portal vein gas, pneumoperitoneum

**The definitions provided (except bronchopulmonary dysplasia) are those described in the manual of operations of the Maternal-Fetal Medicine Units Network for randomized clinical trials designed to prevent prematurity with 17-alpha hydroxyprogesterone caproate*

Clinical – Stage II – Definite

- Treatment was medical

Other findings may include:

- perinatal stress
- systemic manifestations such as temperature instability, lethargy, apnea, bradycardia, occult or gross GI bleeding, abdominal distension
- radiographs show: intestinal distension with ileus, small bowel separation, rigid bowel loops, pneumatosis intestinalis, portal vein gas

Other – Stage I – Suspect

- Treatment was observation

Other findings may include:

- perinatal stress
- systemic manifestations such as temperature instability, lethargy, apnea, bradycardia
- radiographs show: intestinal distension with ileus

<u>Respiratory Distress Syndrome (both diagnosis and oxygen therapy)</u>

- Clinical Diagnosis of at least RDS type I (one or more of the following):
    - tachypnoea (respiratory rate > 60 breaths per minute)
    - intercostal, subcostal, and sternal recession
    - expiratory grunting
    - cyanosis
    - diminished breath sounds

- oxygen therapy ($FiO_2 \geq 0.40$) until infant death or ≥ 24 hours

Retinopathy[6]

- Stage I (ophthalmoloscopic demarcation line of normal and abnormal vessels)
- Stage II (intraretinal ridge (ridge that rises up from the retina as a result of the growth of the abnormal vessels)
- Stage III (ridge with extraretinal fibrovascular proliferation (the ridge grows from the spread of the abnormal vessels and extends into the vitreous)

Bronchopulmonary Dysplasia

- Treatment with > 21% O_2 for at least 28 days, or
- O_2 dependence after 36 weeks post-conceptional age

Proven Sepsis

- Clinically ill infant with suspected infection plus
- Positive blood, CSF, or catheterized/suprapubic urine culture or cardiovascular collapse or unequivocal X-ray finding

Definitions of Composite Perinatal Mortality/Neonatal Morbidity Outcome Scores:

1) 0 to 4 scale without NICU: This score was derived as an ordinal scale based upon severity. The score was defined by the following: 0=no events; 1=one event for (RDS, BPD, grade III or IV IVH, PVL, proven sepsis, or NEC) and no perinatal mortality, 2=two events and no perinatal mortality; 3=three or more events and no perinatal mortality; and 4=perinatal mortality.

2) 0 to 4 scale with NICU: This score was defined as the following: 0=no events, 1=one event for (RDS, BPD, grade III or IV IVH, PVL, proven sepsis, or NEC) or <5 days in the NICU, and no perinatal mortality; 2=two events or between 5 and 20 days in the NICU, and no perinatal mortality; 3=three or more events or >20 days in the NICU, and no perinatal mortality; and 4=perinatal mortality.

3) 0 to 6 scale without NICU: This score was defined as the following: 0=no events; 1=one event for (RDS, BPD, grade III or IV IVH, proven sepsis, or NEC) and no perinatal mortality, 2=two events and no perinatal mortality; 3=three events and no perinatal mortality; 4=four events and no perinatal mortality; 5=five events and no perinatal mortality; and 6=perinatal mortality.

4) Any morbidity or mortality event: (yes/no)

Appendix S2 Definition of Adverse Events

The Medical Dictionary for Regulatory Activities (MedDRA) dictionary (version 11.0) was used to classify all adverse events reported during the study by system organ class and preferred term. The incidence of treatment-emergent adverse events (TEAEs) was also determined. TEAEs were defined as those adverse events that either had an onset time on or after the start of study drug and no more than 30 days after the last dose of study drug, or were ongoing at the time of study drug initiation and increased in severity, or became closer in relationship to study drug during the treatment period.

Appendix S3 Trial Profile

This section describes patients lost to follow-up and protocol violations.

Patients lost to follow-up: There were seven patients lost to follow-up in which the investigators were not able to obtain delivery date. Six patients had been allocated to the placebo group and one to the progesterone group.

Protocol violations: This will be itemized by category:

a) One patient had a cervical length of 21 mm when the upper limit of cervical length for enrollment was 20 mm. This patient was randomised to receive progesterone.

b) One patient was enrolled despite having had a prophylactic cerclage. The protocol required that patients with a cerclage be excluded from participation. This patient was allocated to the placebo group.

c) One patient had a positive test for HIV. The protocol specified that patients testing positive for HIV should be excluded. She was allocated to receive progesterone.

d) Two patients were prescribed progesterone administration. The protocol specified that patients should not have progesterone administration. These two patients were allocated to progesterone administration in the trial.

e) A total of 55 patients began study drug before or after the planned interval of 20 – 23 6/7 weeks, as specified in the protocol, based on the date of the first dose of study drug and the accepted estimated date of confinement. The specific detail for these patients is the following:

i. 20 patients allocated to placebo began therapy before 20 weeks; range 17-19 6/7 weeks

ii. 9 patients allocated to progesterone began therapy before 20 weeks; range 19 – 19 6/7 weeks

iii. 7 patients allocated to placebo began therapy after 23 6/7 weeks; range 24 – 25 weeks

iv. 19 patients allocated to progesterone began therapy after 23 6/7 weeks; range 24 – 25 3/7 weeks

An additional analysis was conducted in which the following patients were removed: (those who started placebo or progesterone before or after the gestational age prescribed in the protocol, those who had a cerclage or those with a history of cervical surgery). This analysis demonstrated a 49% reduction in the rate of preterm birth before 33 weeks of gestation in women who were randomly allocated to receive vaginal progesterone (7.9% (15/189) vs 15.7% (27/172); RR, 0.51; 95%CI, 0.28-0.92; p=0.022). The reduction of preterm birth at <28 weeks of gestation was also statistically significant (4.2% vs 11.1%; RR, 0.38; 95% CI, 0.17-0.85; p=0.014 in this subpopulation. Similarly, the reduction at <35 weeks was also statistically significant (13.2% vs 23.3%; RR, 0.57; 95%CI, 0.36-0.90; p=0.013).

Appendix S4 Frequency Distributions for Perinatal Mortality/Neonatal Morbidity Composite Scores – ITT analysis set

0 – 4 scale

Score	Placebo n	Prochieve n
0	192	217
1	11	5
2	8	2
3	0	3
4	11	8

0 – 4 scale with NICU

Score	Placebo n	Prochieve n
0	168	194
1	11	6
2	17	19
3	15	8
4	11	8

0 – 6 scale

Score	Placebo n	Prochieve n
0	192	217
1	11	5
2	8	2
3	0	0
4	0	3
5	0	0
6	11	8

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WAYNE STATE UNIVERSITY

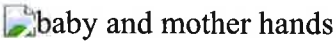
WARRIOR STRONG

School of Medicine News

September 19, 2019

Study: Make Your Date effective against preterm birth

Share



A study conducted by a Wayne State University School of Medicine researcher finds that Make Your Date, a program implemented in Detroit five years ago to help women carry their pregnancies to full term, is having a

positive impact in the battle against preterm birth.

A team led by Adi Tarca, Ph.D., associate professor of Obstetrics and Gynecology, and adjunct associate professor of Computer Science at Wayne State University, conducted an analysis of data from 1,945 women served by the Make Your Date program in 2014 and 2015. The results show a reduction in preterm birth at all stages of pregnancy compared to peers who were not in the program.

Women served by Make Your Date were 37 percent less likely to deliver at less than 32 weeks and 28 percent less likely to deliver at less than 34 weeks than women delivering at the same hospital who had not participated in the program, Dr. Tarca said.

Dr. Tarca and his team are gathering additional data with the expectation of reporting the results in a peer-reviewed international medical journal. One of the questions they will explore is what components of the Make Your Date Program contribute most to the reduction in preterm birth.

Preterm birth is the leading cause of infant mortality worldwide. One in nine babies are born premature in the United States, which ranks the worst among developed nations for infant mortality. In Detroit, one in six babies are born premature. In fact, Detroit is the city with the highest rate of preterm births in the nation, according to the latest March of Dimes report issued in November 2018.

African American infants are at a 50% greater risk of preterm birth and more than twice as likely to die when compared to white infants. African American mothers are three to four times more likely to die in pregnancy than white mothers. Hispanic mothers and infants are also at a greater risk.

A host of health problems are associated with preterm birth, including respiratory problems, bowel abnormalities, infection, sepsis, mental disabilities, cerebral palsy and neonatal death. If children born prematurely survive to school age, they may have more difficulty with spelling, reading and math.

Even with the major reductions found in his research, the preterm birth rate among Make Your Date clients was still above the national average, Dr. Tarca said.

Marisa Rodriguez, project manager for Make Your Date, said, "One of the largest barriers pregnant women in the city encounter is reliable transportation to prenatal care appointments. The recent addition of transportation services to our clients, we believe, holds out the prospect of even greater reductions."

Wayne State University launched the Make Your Date Program in 2014 to reduce the rate of preterm birth in Detroit. The comprehensive outreach effort has provided services to between 1,000 and 1,500 pregnant women in Detroit each year. The program provides education classes, one-on-one counseling, access to insurance, the latest tests and treatment and referrals to numerous services.

Make Your Date is based upon research sponsored by the National Institutes of Health and conducted at WSU that demonstrated a simple treatment of progesterone given to high-risk women with a single pregnancy reduces the rate of preterm birth by 45% and reduces infant morbidity and mortality. A WSU study recently demonstrated that in mothers with a short cervix carrying twins, the administration of vaginal progesterone reduces the risk of infant mortality by 47%.

Directed by Sonia Hassan, M.D., associate vice president of Women's Health in the Office of Health Affairs for Wayne State University, Make Your Date is also based on research conducted by Yale University demonstrating the use of the Expect With Me group prenatal care program reduces the risk of preterm birth by 40% in African American women. Yale University recently conducted additional research, including Make Your Date patients receiving services from this program, and found similar reductions in pregnant mothers seen at WSU.

For more information on the Make Your Date Detroit program, visit www.makeyourdate.org.

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School of Medicine

Scott Hall
Public Affairs, Room 1320
540 E. Canfield
Detroit, MI 48201
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Attachment 4

2014			Total	Total Funding	Subcontractor Count	W/O Duplicates
	Dental Upgrades		20,000		1	1
	Insight Patient Management		26,142		1	1
	Rent		35,559			0
	IPH Security		8,074			0
	Temp Staffing		61,121			0
	DIC Child Development		10,000		1	1
	2014 Total		**160,896**	**1,709,654**	**3**	3
2015						
	Make Your Date	Wayne State University School of Medicine	58,368		1	1
	Pediatric Dental	MI Community Dental Clinics	505,332		1	1
	Fit Kids	Wayne County Childrens Healthcare Access Project	41,006		1	1
	Consultant Epidemiologist	C. Obianwu	15,000		1	1
	Media Purchases	The Media Authority	29,000		1	1
	Accountant	Peter Granaas	7,652		1	1
	Health Promotion Training Materia	Coeffective	100,000		1	1
	IT Contractual	Elite Business Technologies and other	25,200		1	1
	FIMR Suppl Case Abstraction & Maternal Interviewing	M. Ruehle	4,900		1	1
			786,458	**1,709,654**	9	9
2016						
	Pediatric Dental	MCDC	50,000		1	0
	Fit Kids	Wayne County Childrens Healthcare Access Project	41,006		1	0
	Make Your Date	Wayne State University School of Medicine	200,000		1	0
	Group Prenatal/Education Classes	HFHS/WIN Network	10,000		1	1
	Coeffective		10,000		1	0
	Media Purchases	The Media Authority	23,191		1	0
	Death Review/Scene Investigation	MPHI	10,000		1	1
	Birthing Project USA Founder Training Consultant	K. Hall Turjillo	5,000		1	1
	FIMR Suppl Case Abstraction & Maternal Interviewing	M. Ruehle	10,000		1	0
			359,197	**1,709,654**	9	3
2017						
	Make Your Date	Wayne State University School of Medicine	94,938		1	0
	Group	HFHS/WIN Network	10,000		1	0
	Pediatric Dental	Transportation Services	11,000		1	0
	Fit Kids	Wayne County Childrens Healthcare Access Project	40,000		1	0
	Media Purchases	Media Authority	30,000		1	0
	FIMR Suppl Case Abstraction & Maternal Interviewing	M. Ruehle	5,000		1	0
	FIMR Suppl Case Abstraction & Maternal Interviewing	F. Freeman	5,000		1	1
	Sister Friends Evaluation		10,000		1	1
	Pediatric Dental	Advertisement and Outreach	30,000			0
			235,938	**1,809,654**	8	2
2018						
	Media Purchases	Media Authority	52,000		1	0
	Sister Friends Technical Assistance		10,000		1	1
	Media Purchases	Sisterfriends TBD	56,350		1	1
			118,350	**1,809,654**	3	2
2019						
	No Subcontractors					
			-	**1,709,654**		
2014-2019	Total			**10,457,924**		**19**

Attachment 5

Maternal and Child Health Services Title V Block Grant

Michigan

FY 2020 Application/ FY 2018 Annual Report

Created on 5/16/2019 at 10:41 AM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ROBERT GORDON
DIRECTOR

May 1, 2019

Grants Management Officer
Maternal and Child Health Bureau
HRSA Grants Application Center
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

Dear Grants Management Officer:

With this letter of transmittal, I am pleased to submit Michigan's application for the Title V Maternal and Child Health Services Block Grant. The 2020 Application and 2018 Annual Report have been submitted online through the Title V Information System (TVIS) as required.

If you have any questions concerning this application, please contact me at 517-284-4028 or BieryL@michigan.gov.

Sincerely,

Lynette Biery, Director
Bureau of Family Health Services
Michigan Department of Health and Human Services

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www.michigan.gov/mdhhs • 517-373-3740

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Michigan's Title V Maternal and Child Health (MCH) program[1] supports a wide range of critical MCH programs and services across the state. Its overarching goal is to improve the health and well-being of the state's mothers, infants, children, and adolescents—including children with special health care needs (CSHCN). The Michigan Department of Health and Human Services (MDHHS) administers the Title V block grant through the Bureau of Family Health Services (BFHS) within the Population Health Administration. The Children's Special Health Care Services (CSHCS) Division, which is housed in the Bureau of Medicaid Care Management and Quality Assurance within the Medical Services Administration, serves as the Title V CSHCN program.

The BFHS and the CSHCS Division provide leadership on MCH programs and policies, including direct oversight of statewide multisystem collaborative initiatives that have been instrumental to achieving success. In 2017, Michigan created a Maternal Infant Strategy Group (MISG) to provide leadership to align maternal and infant health goals and strategies across private and public stakeholders and to provide guidance on operationalizing a health equity lens in MCH programs. The multisystem decision makers seated on the MISG have set *zero preventable deaths and zero health disparities* as the vision for Michigan's Mother Infant Health and Equity Improvement Plan, known as the Improvement Plan. In 2018, input into the Improvement Plan was solicited from established partners (local public health, managed care plans, universities, Medicaid, Michigan Department of Education, and MDHHS program areas such as epidemiology, mental health and substance abuse, chronic disease, communicable disease, injury prevention, health disparities reduction and minority health) as well as families and partners from key social determinants of health sectors. Local communities are currently being engaged to identify strategies that best fit their needs and to set community-specific, measurable outcomes. The Improvement Plan incorporates many of Michigan's Title V priority areas.

Michigan's current state priorities were determined by the five-year needs assessment completed in 2015. Per Title V requirements, the assessment was used to identify needs for preventive and primary care services for women, mothers, infants, and children as well as services for CSHCN. Leaders with expertise in each of the Title V population domains were engaged in the planning and implementation processes. The goals of the assessment were to:

- Engage stakeholders to assess needs, strengths, and capacity;
- Utilize existing data and stakeholder expertise to identify strategic issues to improve health in each of the population domains; and
- Identify priority unmet needs in each population domain and strategies for addressing these needs.

Based on the needs assessment findings, the following state priority needs were identified:

- Reduce barriers, improve access, and increase the availability of health services for all populations
- Support coordination and linkage across the perinatal to pediatric continuum of care
- Invest in prevention and early intervention strategies
- Increase family and provider support and education for Children with Special Health Care Needs
- Increase access to and utilization of evidence-based oral health practices and services
- Foster safer homes, schools, and environments with a focus on prevention
- Promote social and emotional well-being through the provision of behavioral health services

National Performance Measures (NPMs) and State Performance Measures (SPMs) were chosen to align with the identified priority needs. State action plans were then developed which include Evidence-based or -informed Strategy Measures (ESMs). Performance monitoring and program planning for NPMs and SPMs occurs on an ongoing basis. For example, MCH program staff review program results, client and family feedback, best practices, and emerging evidence to identify improvements to programs and policies. In 2018, program staff created logic models that identified goals, barriers, resources, evidence-based strategies, outputs, and outcomes to inform the Title V state action plans.

Based on the new Title V Guidance issued December 31, 2017, and in conjunction with ongoing needs assessment activities, Michigan reevaluated its original NPMs and SPMs and made adjustments to better align with current program and funding priorities. Detailed state action plans (which include program objectives, strategies, and performance data) are included in Section III.E. A brief summary by population domain is below.

Women/Maternal Health

The first goal in this population domain is to increase the percent of women with a past year preventive medical visit. Although 67.0% of women between the ages of 18 and 44 years received a preventive medical visit in Michigan during 2013, significant disparities exist, with only 47.3% of women who were uninsured receiving a preventive medical visit[2]. Thus, a key role for MDHHS is to help women access insurance and connect with primary care providers. The Title V plan focuses on ensuring women have the reproductive and health care services they need to achieve optimal health, including planning for pregnancy. Key objectives are to maintain a high percentage of women who use a most effective or moderately effective contraceptive method and to increase the percentage of women who discuss reproductive life planning with a health professional.

The second goal in this domain is to increase the percent of women with a preventive dental visit during pregnancy. The needs assessment found that only 44.5% of women had their teeth cleaned during their most recent pregnancy[3]. Michigan has seen improvement on this measure, with the most recent data indicating that 53.6% of women received a preventive dental visit.[4] Strategies to address this issue include increasing access to the WIC oral health module; training medical and dental providers who treat pregnant women; and participating in pilot programs to provide oral health services in OB units of FQHCs.

Perinatal/Infant Health

The first perinatal/infant health goal is to increase the percent of very low birth weight infants born in a hospital with a Level III+ NICU. While Michigan has seen improvements over time—from 78.0% in 2008 to 90% in 2017[5]—the needs assessment revealed challenges in Michigan's perinatal to pediatric continuum of care, such as racial disparities in first trimester prenatal care, preterm births, and infant mortality. Regional perinatal care systems are a key strategy to assure the most vulnerable infants and mothers receive appropriate services. Therefore, Michigan is supporting and expanding regional perinatal care systems; promoting the use of evidence-based programs such as home visiting and CenteringPregnancy; and expanding quality improvement efforts to prevent and respond to perinatal substance use.

The second goal is to increase the percent of infants who are ever breastfed and the percent of infants breastfed exclusively through six months. While breastfeeding rates have increased in Michigan over the past several years, they are still short of the Healthy People 2020 objectives (81.9% of infants ever breastfed and 25.5% of infants exclusively breastfed through six months). In Michigan, 75.9% of infants are ever breastfed and 22.6% are exclusively breastfed through six months[6]. To impact breastfeeding rates, MDHHS is implementing strategies to increase the number of Baby-Friendly© hospitals and to reduce the gap in breastfeeding rates between non-Hispanic white and

Attachment 6

CITY OF DETROIT

Financial Detail by Appropriation and Organization

Department

25 Department of Health and Wellness Promotion

Total Expenditures

	2013-14 Actuals	EM Budget 14 – 2015	EM Budget 2016	2016-17 Proposed	2017-18 Proposed	2018-19 Proposed
258405 Lead Poisoning Prev(MDCH) 9/2015		100,000				
13680 Lead Intervention(MDCH) 9/2015		**215,000**				
258406 Lead Intervention(MDCH) 9/2015		215,000				
13681 ELPHS Food 9/2015		**530,000**				
253057 ELPHS Food 9/2015		530,000				
13682 ELPHS MDCH other 9/2015		**3,100,000**				
253058 ELPHS MDCH other 9/2015		3,100,000				
13683 Bio-Terrorism Emerg Prep 9/2015		**206,000**				
253059 Bio-Terrorism Emerg Prep 9/2015		206,000				
13684 Cities Readiness Inititives 9/2015		**240,000**				
253060 Cities Readiness Inititives 9/2015		240,000				
13685 CSHCS Outreach & Advocacy 9/2015		**807,000**				
253061 CSHCS Outreach & Advocacy 9/2015		807,000				
13686 Family Planning 9/2015		**800,000**				
253062 Family Planning 9/2015		800,000				
13687 Fetal infant Mortality Review 9/2015		**3,000**				
253063 Fetal Infant Mortality Review 9/2015		3,000				
13688 HIV/AIDS Prevention 9/2015		**620,000**				
253064 HIV/AIDS Prevention 9/2015		620,000				
13689 HIV/AIDS Testing Dental 9/2015		**20,000**				
253065 HIV/AIDS Testing Dental 9/2015		20,000				
13690 Immunization Action Plan 9/2015		**360,000**				
253066 Immunization Action Plan 9/2015		360,000				
13691 Infant Safe Sleep 9/2015		**45,000**				
253067 Infant Safe Sleep 9/2015		45,000				
13692 Local Maternal & Child Hlth 9/2015		**1,710,000**				
253068 Local maternal & Child Hlth 9/2015		1,710,000				

CITY C :ETROIT
Budget Development
Financial Detail by Appropriation and Organization

Appropriation / Organization	2015-16 Adopted	2016-17 Recommended	2017-18 Forecast	2018-19 Forecast	2019-20 Forecast
252821 HIV/Ryan White 9/2017_FD2104	-	50,000	50,000	50,000	50,000
20217 DHWP Immunization Action Plan 9/2017 FD2	-	**361,587**	**361,587**	**361,587**	**361,587**
252822 Immunization Action Plan 9/2017_FD2104	-	361,587	361,587	361,587	361,587
20218 DHWP Infant Safe Sleep 9/2017 FD2104	-	**45,000**	**45,000**	**45,000**	**45,000**
252823 Infant Safe Sleep 9/2017_FD2104	-	45,000	45,000	45,000	45,000
20219 DHWP Local Maternal & Child Hlth 9/2017	-	**1,709,654**	**1,709,654**	**1,709,654**	**1,709,654**
252824 Local Maternal & Child Hlth 9/2017_FD210	-	1,709,654	1,709,654	1,709,654	1,709,654
20220 DHWP Hearing-MDCH 9/2017 FD2104	-	**370,000**	**370,000**	**370,000**	**370,000**
252825 Hearing-MDCH 9/2017_FD2104	-	370,000	370,000	370,000	370,000
20221 DHWP Vision-MDCH 9/2017 FD2104	-	**370,000**	**370,000**	**370,000**	**370,000**
252826 Vision-MDCH 9/2017_FD2104	-	370,000	370,000	370,000	370,000
20222 DHWP HIV Emerg Supp Relief 2/2018 FD2104	-	**9,000,000**	**9,000,000**	**9,000,000**	**9,000,000**
258807 HIV Emerg Supp Relief 2/2018_FD2104	-	9,000,000	9,000,000	9,000,000	9,000,000
20223 DHWP HOPWA Aids Housing 6/2017 FD2104	-	**2,100,000**	**2,100,000**	**2,100,000**	**2,100,000**
258808 HOPWA Aids Housing 6/2017_FD2104	-	2,100,000	2,100,000	2,100,000	2,100,000
AGENCY GRAND TOTAL	**33,118,512**	**28,914,667**	**33,669,384**	**33,654,718**	**33,655,306**

Attachment 7

PROFESSIONAL SERVICES CONTRACT

BETWEEN

CITY OF DETROIT, MICHIGAN

AND

Southeastern Michigan Health Association

CONTRACT NO.

6000359

Contract Number Changed to 6000468

Table of Contents

CITY OF DETROIT
PROFESSIONAL SERVICES CONTRACT

This Professional Services Contract ("Contract") is entered into by and between the City of Detroit, a Michigan municipal corporation, acting by and through its Health Department ("City"), and Southeastern Michigan Health Association, a Michigan Non-Profit Corporation, ("Fiduciary" or "Contractor") with its principal place of business located at 200 Fisher Building, 3011 W. Grand Boulevard Detroit MI, 48202.

Recitals:

Whereas, the City of Detroit Health Department is a local public health department organized under the Michigan Health Code, P.A. 368 of the Public Acts of 1978, as amended which receives grant funding from various sources; and

Whereas, the City desires to engage the Contractor to render certain technical or professional services ("Services") in the administration of said grant funding, as set forth in this Contract; and

Whereas, the Contractor desires to perform the Services as set forth in this Contract; and Accordingly, the parties agree as follows:

Article 1: Definitions

1.01 The following words and expressions or pronouns used in their stead shall be construed as follows:

"Additional Services" shall mean any services in addition to the services set forth in Exhibit A that are related to fulfilling the objectives of this Contract and are agreed upon by the parties by written Amendment.

"Amendment" shall mean modifications or changes in this Contract that have been mutually agreed upon by the City and the Contractor in writing and approved by the City Council.

"Associates" shall mean the personnel, employees, consultants, subcontractors, agents, and parent company of the Contractor or of any Subcontractor, now existing or subsequently created, and their agents and employees, and any entities associated, affiliated, or subsidiary to the Contractor or to any subcontractor, now existing or subsequently created, and their agents and employees.

"City" shall mean the City of Detroit, a municipal corporation, acting through the office or department named in the Contract as contracting for the Services on behalf of the City.

"City Council" shall mean the legislative body of the City of Detroit.

"Contract" shall mean each of the various provisions and parts of this document, including all attached Exhibits and all Amendments, as executed and approved by the appropriate City departments or offices and by the City Council.

"Contractor" shall mean the party that contracts with the City by way of this Contract, whether an individual, sole proprietorship, partnership, corporation, or other form of business organization, and its heirs, successors, personnel, agents, employees, representatives, executors, administrators and assigns.

"Exhibit A" is the Scope of Services for this Contract and sets forth all pertinent data relating to performance of the Services.

"Exhibit B" is the Fee Schedule for this Contract and sets forth the amount of compensation to be paid to the Contractor, including any Reimbursable Expenses, and any applicable hourly rate information.

"Fiduciary" shall mean Southeastern Michigan Health Association, a vendor, whether incorporated as a firm or individual, or whether a partnership or any combination thereof, and its heirs or successors, personnel, representatives, executors, administrators and assigns.

"Public Servant" means the Mayor, members of City Council, City Clerk, appointive officers, any member of a board, commission or other voting body established by either branch of City government or the City Charter, and any appointee, employee or individual who provides services to the City within or outside of its offices or facilities pursuant to a personal services contract.

"Records" shall mean all books, ledgers, journals, accounts, documents, and other collected data in which information is kept regarding the performance of this Contract.

"Reimbursable Expenses" shall mean only those costs incurred by the Contractor in the performance of the Services, such as travel costs and document reproduction costs that are identified in Exhibit B as reimbursable.

"Services" shall mean all work that is expressly set forth in Exhibit A, the Scope of Services, and all work expressly or impliedly required to be performed by the Contractor in order to achieve the objectives of this Contract.

"Subcontractor" shall mean any person, firm or corporation, other than employees of the Contractor, that contracts with the Contractor, directly or indirectly, to perform in part or assist the Contractor in achieving the objectives of this Contract.

"Technology" shall mean any and all computer-related components and systems, including but not limited to computer software, computer code, computer programs, computer hardware, embedded integrated circuits, computer memory and data storage systems, whether in the form of read-only memory chips, random access memory chips, CD-ROMs, floppy disks, magnetic tape, or some other form, and the data retained or stored in said computer memory and data storage systems.

"Unauthorized Acts" shall mean any acts by a City employee, agent or representative that are not set forth in this Contract and have not been approved by City Council as part of this Contract.

"Work Product" shall mean the originals, or copies when originals are unavailable, of all materials prepared by the Contractor under this Contract or in anticipation of this Contract, including but not limited to Technology, data, studies, briefs, drawings, maps, models, photographs, files, records, computer printouts, estimates, memoranda, computations, papers, supplies, notes, recordings, and videotapes, whether such materials are reduced to writing, magnetically or optically stored, or kept in some other form.

Article 2: Engagement of Contractor

2.01 By this Contract, the City engages the Contractor and the Contractor hereby agrees to faithfully and diligently perform the Services set forth in Exhibit A, in accordance with the terms and conditions contained in this Contract.

2.02 The Contractor shall perform in a satisfactory manner as shall be determined within the sole and reasonable discretion of the City. In the event that there shall be any dispute between the parties with regard to the extent, character and progress of the Services to be performed or the quality of performance under this Contract, the interpretation and determination of the City shall govern.

2.03 The Contractor shall confer as necessary and cooperate with the City in order that the Services may proceed in an efficient and satisfactory manner. The Services are deemed to include all conferences, consultations and public hearings or appearances deemed necessary by the City to ensure that the Contractor will be able to properly and fully perform the objectives as set forth in this Contract.

2.04 All Services are subject to review and approval of the City for completeness and fulfillment of the requirements of this Contract. Neither the City's review, approval nor payment for any of the Services shall be construed to operate as a waiver of any rights under this Contract, and the Contractor shall be and will remain liable in accordance with applicable law for all damages to the City caused by the Contractor's negligent performance or nonperformance of any of the Services furnished under this Contract.

2.05 The Services shall be performed as set forth in Exhibit A, or at such other locations as are deemed appropriate by the City and the Contractor for the proper performance of the Services.

2.06 The City and the Contractor expressly acknowledge their mutual understanding and agreement that there are no third party beneficiaries to this Contract and that this Contract shall not be construed to benefit any persons other than the City and the Contractor.

2.07 It is understood that this Contract is not an exclusive services contract, that during the term of this Contract the City may contract with other firms, and that the Contractor is free to render the same or similar services to other clients, provided the rendering of such services does not affect the Contractor's obligations to the City in any way.

Article 3: Contractor's Representations and Warranties

3.01 To induce the City to enter into this Contract, the Contractor represents and warrants that the Contractor is authorized to do business under the laws of the State of Michigan and is duly qualified to perform the Services as set forth in this Contract, and that the execution of this Contract is within the Contractor's authorized powers and is not in contravention of federal, state or local law.

3.02 The Contractor will ensure that any subcontracts recommended by the City will contain the following representations and warranties as to any Technology it may provide under the subcontract:

a) That all Technology provided to the City under this Contact shall perform according to the specifications and representations set forth in Exhibit A and according to any other specifications and representations, including any manuals, provided by the Contractor to the City;

b) That the Contractor shall correct all errors in the Technology provided under this Contract so that such technology will perform according to Contractor's published specifications;

c) That the Contractor has the full right and power to grant the City a license to use the Technology provided pursuant to this Contract;

d) That any Technology provided by Contractor under this Contract is free of any software, programs or routines, commonly known as "disabling code," that are designed to cause such Technology to be destroyed, damaged, or otherwise made inoperable in the course of the use of the Technology;

e) That any Technology containing computer code and provided under this Contract is free of any known or reasonably discoverable computer program, code or set of instructions, commonly known as a "computer virus," that is not designed to be a part of the Work Product and that, when inserted into the computer's memory: (i) duplicates all or part of itself without specific user instructions to do so, or (ii) erases, alters or renders unusable any Technology with or without specific user instructions to do so, or (iii) that provide unauthorized access to the Technology and

3.03 That all Technology shall be delivered new and in original manufacturer's packaging and shall be fully warranted for repair or replacement during the term of this Contract as amended or extended.

3.04 That any Technology that it is provided to the City shall:

a) Accurately recognize and process all time and date data including, but not limited to, daylight savings time and leap year data, and

b) Use accurate same-century, multi-century, and similar date value formulas in its calculations, and use date data interface values that accurately reflect the correct time, date and century.

Article 4: Contract Effective Date and Time of Performance

4.01 This Contract shall be approved by the required City departments, approved by the City Council, and signed by the City's Chief Procurement Officer. The term of this Contract shall begin on 10/01/2016 and shall terminate on 09/30/2018.

4.02 Prior to the approvals set forth in Section 4.01, the Contractor shall have no authority to begin work on this Contract. The Chief Procurement Officer shall not authorize any payments to the Contractor, nor shall the City incur any liability to pay for any services rendered or to reimburse the Contractor for any expenditure, prior to such award and approvals.

4.03 The City and the Contractor agree that the commencement and duration of the Contractor's performance under this Contract shall be determined as set forth in Exhibit A.

Article 5: Data to Be Furnished Contractor

5.01 Copies of all information, reports, records, and data as are existing, available, and deemed necessary by the City for the performance of the Services shall be furnished to the Contractor upon the Contractor's request. With the prior approval of the City, the Contractor will be permitted access to City offices during regular business hours to obtain any necessary data. In addition, the City will schedule appropriate conferences at convenient times with administrative personnel of the City for the purpose of gathering such data.

Article 6: Contractor Personnel and Contract Administration

6.01 The Contractor represents that, at its own expense, it has obtained or will obtain all personnel and equipment required to perform the Services. It warrants that all such personnel are qualified and possess the requisite licenses or other such legal qualifications to perform the services assigned. If requested, the Contractor shall supply a résumé of the managerial staff or consultants it proposes to assign to this Contract, as well as a dossier on the Contractor's professional activities and major undertakings.

6.02 The relationship of the Contractor to the City is and shall continue to be that of an independent contractor and no liability or benefits, such as workers' compensation, pension rights or liabilities, insurance rights or liabilities, or other rights or liabilities arising out of or related to a contract for hire or employer/employee relationship shall arise or accrue to either party or either party's agent, Subcontractor or employee as a result of the performance of this Contract. No relationship other than that of independent contractor shall be implied between the parties or between either party's agents, employees or Subcontractors. The Contractor agrees to indemnify, defend, and hold the City harmless against any claim based in whole or in part on an allegation that the Contractor or any of its Associates qualify as employees of the City, and any related costs or expenses, including but not limited to legal fees and defense costs.

6.03 The Contractor warrants and represents that all persons assigned to the performance of this Contract shall be regular employees or independent contractors of the Contractor, unless otherwise authorized by the City. The Contractor's employees' daily working hours while working in or about a City of Detroit facility shall be the same as those worked by City employees working in the facility, unless otherwise directed by the City.

6.04 The Contractor shall comply with and shall require its Associates to comply with all security regulations and procedures in effect on the City's premises.

Article 7: Compensation

7.01 Compensation for Services provided shall not exceed the amount of $41,100,000 and 00/100 Dollars ($), inclusive of expenses, and will be paid in the manner set forth in Exhibit B. Unless this Contract is amended pursuant to Article 16, this amount shall be the entire compensation to which the Contractor is entitled for the performance of Services under this Contract.

7.02 Payment for Services provided under this Contract is governed by the terms of Ordinance No. 42-98, entitled "Prompt Payment of Vendors," being Sections 18-5-71 through 18-5-79 of the 1984 Detroit City Code.

The City employee responsible for accepting performance under this Contract is:

Abdul El-Sayed, MD, DPhil
Executive Director & Health Officer
City of Detroit
Detroit Health Department
3245 E. Jefferson Ave, Suite 100
Detroit, MI 48207
Telephone: 313.876.0301
Email: elsayeda@detroitmi.gov

The City employee from whom payment should be requested is:

Abdul El-Sayed, MD, DPhil
Executive Director & Health
Officer City of Detroit
Detroit Health Department
3245 E. Jefferson Ave, Suite 100
Detroit, MI 48207
Telephone: 313.876.0301
Email: elsayeda@detroitmi.gov

Article 8: Maintenance and Audit of Records

8.01 The Contractor shall maintain full and complete Records reflecting all of its operations related to this Contract. The Records shall be kept in accordance with generally accepted accounting principles and maintained for a minimum of three (3) years after the Contract completion date.

8.02 The City and any government-grantor agency providing funding under this Contract shall have the right at any time without notice to examine and audit all Records and other supporting data of the Contractor as the City or any agency deems necessary.

a) The Contractor shall make all Records available for examination during normal business hours at its Detroit offices, if any, or alternatively at its facility nearest Detroit. The City and any government-grantor agency providing funds for the Contract shall have this right of inspection. The Contractor shall provide copies of all Records to the City or to any such government-grantor agency upon request.

b) If in the course of such inspection the representative of the City or of another government-grantor agency should note any deficiencies in the performance of the Contractor's agreed upon performance or record-keeping practices, such deficiencies will be reported to the Contractor in writing. The Contractor agrees to promptly remedy and correct any such reported deficiencies within ten (10) days of notification.

c) Each party shall pay its own audit costs.

d) Nothing contained in this Contract shall be construed or permitted to operate as any restriction upon the powers granted to the Auditor General by the City Charter, including but not limited to the powers to audit all accounts chargeable against the City and to settle disputed claims.

8.03 The Contractor agrees to include the covenants contained in Sections 8.01 and 8.02 in any contract it has with any Subcontractor, consultant or agent whose services will be charged directly or indirectly to the City for Services performed pursuant to this Contract.

Article 9: Indemnity

9.01 The Contractor agrees to indemnify, defend, and hold the City harmless against and from any and all liabilities, obligations, damages, penalties, claims, costs, charges, losses and expenses (including, without limitation, fees and expenses for attorneys, expert witnesses and other consultants) that may be imposed upon, incurred by, or asserted against the City or its departments, officers, employees, or agents by reason of any of the following occurring during the term of this Contract:

a) Any negligent or tortious act, error, or omission attributable in whole or in part to the Contractor or any of its Associates; and

b) Any failure by the Contractor or any of its Associates to perform their obligations, either express or implied, under this Contract; and

c) Any and all injury to the person or property of an employee of the City where such injury arises out of the Contractor's or any of its Associates performance of this Contract.

9.02 The Contractor shall examine all places where it will perform the Services in order to determine whether such places are safe for the performance of the Services. The Contractor undertakes and assumes all risk of dangerous conditions when not performing Services inside City offices. The Contractor also agrees to waive and release any claim or liability against the City for personal injury or property damage sustained by it or its Associates while performing under this Contract on premises that are not owned by the City.

9.03 In the event any action shall be brought against the City by reason of any claim covered under this Article 9, the Contractor, upon notice from the City, shall at its sole cost and expense defend the same.

9.04 The Contractor agrees that it is the Contractor's responsibility and not the responsibility of the City to safeguard the property that the Contractor or its Associates use while performing this Contract. Further, the Contractor agrees to hold the City harmless for any loss of such property used by any such person pursuant to the Contractor's performance under this Contract.

9.05 The indemnification obligation under this Article 9 shall not be limited by any limitation on the amount or type of damages, compensation, or benefits payable under workers' compensation acts or other employee benefit acts.

9.06 The Contractor agrees that this Article 9 shall apply to all claims, whether litigated or not, that may occur or arise between the Contractor or its Associates and the City and agrees to indemnify, defend and hold the City harmless against any such claims.

Article 10: Insurance

10.01 During the term of this Contract, the Contractor shall maintain the following insurance, at a minimum and at its expense:

TYPE	AMOUNT NOT LESS THAN
a. Workers' Compensation	Michigan Statutory minimum
b. Employers' Liability	$500,000.00 minimum each disease $500,000.00 minimum each person $500,000.00 minimum each accident
c. Commercial General Liability	$1,000,000.00 each occurrence $2,000,000.00 aggregate
d. Automobile Liability Insurance (covering all owned, hired and non-owned vehicles with personal and property protection insurance, including residual liability insurance under Michigan no fault insurance law)	$1,000,000.00 combined single limit for bodily injury and property damage

10.02 The commercial general liability insurance policy shall include an endorsement naming the "City of Detroit" as an additional insured. The additional insured endorsement shall provide coverage to the additional insured with respect to liability arising out of the named insured's ongoing work or operations performed for the additional insured under the terms of this Contract. The commercial general liability policy shall state that the Contractor's insurance is primary and not excess over any insurance already carried by the City of Detroit and shall provide blanket contractual liability insurance for all written contracts.

10.03 Each such policy shall contain the following cross-liability wording: "In the event of a claim being made hereunder by one insured for which another insured is or may be liable, then this policy shall cover such insured against whom a claim is or may be made in the same manner as if separate policies had been issued to each insured hereunder."

10.04 All insurance required by this Contract shall be written on an occurrence-based policy form, if the same is commercially available.

10.05 The Commercial General Liability policy shall be endorsed to have the general aggregate apply to the Services provided under this Contract only.

10.06 If during the term of this Contract changed conditions or other pertinent factors should, in the reasonable judgment of the City, render inadequate the insurance limits, the Contractor shall furnish on demand such additional coverage or types of coverage as may reasonably be required under the circumstances. All such insurance shall be effected at the Contractor's expense, under valid and enforceable policies, issued by insurers licensed to conduct business in Michigan and are otherwise acceptable to the City.

10.07 All insurance policies shall name the Contractor as the insured. Certificates of insurance evidencing the coverage required by this Article 10 shall, in a form acceptable to the City, be submitted to the City prior to the commencement of the Services and at least fifteen (15) days prior to the expiration dates of expiring policies. In the event the Contractor receives notice of policy cancellation, the Contractor shall immediately notify the City in writing.

10.08 If any work is subcontracted in connection with this Contract, the Contractor shall require each Subcontractor to effect and maintain the types and limits of insurance set forth in this Article 10 and shall require documentation of same, copies of which documentation shall be promptly furnished the City.

10.09 The Contractor shall be responsible for payment of all deductibles contained in any insurance required under this Contract. The provisions requiring the Contractor to carry the insurance required under this Article 10 shall not be construed in any manner as waiving or restricting the liability of the Contractor under this Contract.

Article 11: Default and Termination

11.01 This Contract shall remain in full force and effect until the end of its term unless otherwise terminated for cause or convenience according to the provisions of this Article 11.

11.02 The City reserves the right to terminate this Contract for cause. Cause is an event of default.

a) An event of default shall occur if there is a material breach of this Contract, and shall include the following:

1) The Contractor fails to begin work in accordance with the terms of this Contract; or

2) The Contractor, in the judgment of the City, is unnecessarily, unreasonably, or willfully delaying the performance and completion of the Work Product or Services; or

3) The Contractor ceases to perform under the Contract; or

4) The City is of the opinion that the Services cannot be completed within the time provided and that the delay is attributable to conditions within the Contractor's control; or

5) The Contractor, without just cause, reduces its work force on this Contract to a number that would be insufficient, in the judgment of the City, to complete the Services within a reasonable time, and the Contractor fails to sufficiently increase such work force when directed to do so by the City; or

6) The Contractor assigns, transfers, conveys or otherwise disposes of this Contract in whole or in part without prior approval of the City; or

7) Any City officer or employee acquires an interest in this Contract so as to create a conflict of interest; or

8) The Contractor violates any of the provisions of this Contract, or disregards applicable laws, ordinances, permits, licenses, instructions or orders of the City; or

9) The performance of the Contract, in the sole judgment of the City, is substandard, unprofessional, or faulty and not adequate to the demands of the task to be performed; or

10) The Contractor fails in any of the agreements set forth in this Contract; or

11) The Contractor ceases to conduct business in the normal course; or

12) The Contractor admits its inability to pay its debts generally as they become due.

b) If the City finds an event of default has occurred, the City may issue a Notice of Termination for Cause setting forth the grounds for terminating the Contract. Upon receiving a Notice of Termination for Cause, the Contractor shall have ten (10) calendar days within which to cure such default. If the default is cured within said ten (10) day period, the right of termination for such default shall cease. If the default is not cured to the satisfaction of the City, this ~~Contract shall terminate on the tenth calendar day after the Contractor's receipt of the Notice~~ of Termination for Cause, unless the City, in writing, gives the Contractor additional time to cure the default. If the default is not cured to the satisfaction of the City within the additional time allowed for cure, this Contract shall terminate for cause at the end of the extended cure period.

c) If, after issuing a Notice of Termination for Cause, the City determines that the Contractor was not in default, the rights and obligations of the parties shall be the same as if the Notice of Termination had been issued as a Notice of Termination for Convenience. Alternatively,

in the City's discretion, the Notice of Termination for Cause may be withdrawn and the Contract, if terminated, may be reinstated.

d) The Contractor shall be liable to the City for any damages it sustains by virtue of the Contractor's breach or any reasonable costs the City might incur in enforcing or attempting to enforce this Contract. Such costs shall include reasonable fees and expenses for attorneys, expert witnesses and other consultants. However, if the Contractor makes a written offer prior to the initiation of litigation or arbitration, then the City shall not be entitled to such attorney fees unless the City declines the offer and obtains a verdict or judgment for an amount more than ten percent (10%) above the amount of the Contractor's last written offer prior to the initiation of litigation or arbitration. The City may withhold any payment(s) to the Contractor, in an amount not to exceed the amount claimed in good faith by the City to represent its damages, for the purpose of setoff until such time as the exact amount of damages due to the City from the Contractor is determined. It is expressly understood that the Contractor shall remain liable for any damages the City sustains in excess of any setoff.

e) The City's remedies outlined in this Article 11 shall be in addition to any and all other legal or equitable remedies permissible.

11.03 The City shall have the right to terminate this Contract at any time at its convenience by giving the Contractor thirty (30) business days written Notice of Termination for Convenience. As of the effective date of the termination, the City will be obligated to pay the Contractor the following: (a) the fees or commissions for Services completed and accepted in accordance with Exhibit A in the amounts provided for in Exhibit B; (b) the fees for Services performed but not completed prior to the date of termination in accordance with Exhibit A in the amounts set forth in the Contractor's rate schedule as provided in Exhibit B; and (c) the Contractor's costs and expenses incurred prior to the date of the termination for items that are identified in Exhibit B. The amount due to the Contractor shall be reduced by payments already paid to the Contractor by the City. In no event shall the City pay the Contractor more than maximum price, if one is stated, of this Contract.

11.04 The Contractor shall have the right to terminate this Contract at any time at its convenience by giving the City thirty (30) business days written Notice of Termination for Convenience. Said right to terminate shall only arise when: (1) Contractor's expenditures for reimbursement are undisputed by the City; (2) said expenditures have been submitted as required by this Contract; and (3) any amount undisputed by the City has not been paid for forty (40) consecutive business days. As of the effective date of the termination, the Contractor will be obligated to: (a) provide a final invoice or accounting to the City indicating the fees or commissions for services completed and accepted in accordance with Exhibit A in the amounts provided for in Exhibit B; (b) a final invoice or accounting to the City indicating the fees for Services performed but not completed prior to the date of termination in accordance with Exhibit A in the amounts set forth in the Contractor's rate schedule as provided in Exhibit B; and (c) the Contractor's costs and expenses incurred prior to the date of the termination for items that are identified in Exhibit B. Upon receipt of Notice of Termination pursuant to this section, the City shall promptly pay to the Contractor all undisputed amounts due and owing as indicated in the invoice or accounting. The amount due to the Contractor shall be reduced by payments already paid to the Contractor by the City. In no event shall the City pay the Contractor more than the maximum price, if one is stated, of this Contract.

11.05 After receiving a Notice of Termination for Cause or Convenience, and except as otherwise directed by the City, the Contractor shall:

a) Stop work under the Contract on the date and to the extent specified in the Notice of Termination;

b) Obligate no additional Contract funds for payroll costs and other costs beyond such date as the City shall specify, and place no further orders on subcontracts for material, services, or facilities, except as may be necessary for completion of such portion of the Services under this Contract as is not terminated;

c) Terminate all orders and subcontracts to the extent that they relate to the portion of the Services terminated pursuant to the Notice of Termination;

d) Preserve all Records and submit to the City such Records and reports as the City shall specify, and furnish to the City an inventory of all furnishings, equipment, and other property purchased for the Contract, if any, and carry out such directives as the City may issue concerning the safeguarding or disposition of files and property; and

e) Submit within thirty (30) days a final report of receipts and expenditures of funds relating to this Contract, and a list of all creditors, Subcontractors, lessors and other parties, if any, to whom the Contractor has become financially obligated pursuant to this Contract.

11.06 After termination of the Contract, each party shall have the duty to assist the other party in the orderly termination of this Contract and the transfer of all rights and duties arising under the Contract, as may be necessary for the orderly, un-disrupted continuation of the business of each party.

Article 12: Assignment

12.01 Neither party shall assign, transfer, convey or otherwise dispose of any interest whatsoever in this Contract without the prior written consent of the other party; however, claims for money due or to become due to the Contractor may be assigned to a financial institution without such approval. Notice of any assignment to a financial institution or transfer of such claims of money due or to become due shall be furnished promptly to the City. If the Contractor assigns all or any part of any monies due or to become due under this Contract, the instrument of assignment shall contain a clause stating that the right of the assignee to any monies due or to become due shall be subject to prior liens of all persons, firms, and corporations for Services rendered or materials supplied for the performance of the Services called for in this Contract.

Article 13: Subcontracting

13.01 None of the Services covered by this Contract shall be subcontracted without the prior written approval of the City and, if required, any grantor agency. The City reserves the right to withhold approval of subcontracting such portions of the Services where the City determines that such subcontracting is not in the City's best interests.

13.02 Each subcontract entered into shall provide that the provisions of this Contract shall apply to the Subcontractor and its Associates in all respects. The Contractor agrees to bind each Subcontractor and each Subcontractor shall agree to be bound by the terms of the Contract insofar as applicable to the work or services performed by that Subcontractor.

13.03 The Contractor and the Subcontractor jointly and severally agree that no approval by the City of any proposed Subcontractor, nor any subcontract, nor anything in the Contract, shall create or be deemed to create any rights in favor of a Subcontractor and against the City, nor shall it be deemed or construed to impose upon the City any obligation, liability or duty to a Subcontractor, or to create any contractual relation whatsoever between a Subcontractor and the City.

13.04 The provisions contained in this Article 13 shall apply to subcontracting by a Subcontractor of any portion of the work or services included in an approved subcontract.

13.05 The Contractor agrees to indemnify, defend, and hold the City harmless against any claims initiated against the City pursuant to any subcontracts the Contractor enters into in performance of this Contract. The City's approval of any Subcontractor shall not relieve the Contractor of any of its responsibilities, duties and liabilities under this Contract. The Contractor shall be solely responsible to the City for the acts or defaults of its Subcontractors and of each Subcontractor's Associates, each of whom shall for this purpose be deemed to be the agent or employee of the Contractor.

Article 14: Conflict of Interest

14.01 The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of the Services under this Contract. The Contractor further covenants that in the performance of this Contract no person having any such interest shall be employed by it.

14.02 The Contractor further covenants that no officer, agent, or employee of the City and no other public official who exercises any functions or responsibilities in the review or approval of the undertaking or performance of this Contract has any personal or financial interest, direct or indirect, in this Contract or in its proceeds, whether such interest arises by way of a corporate entity, partnership, or otherwise.

14.03 The Contractor warrants (a) that it has not employed and will not employ any person to solicit or secure this Contract upon any agreement or arrangement for payment of a commission, percentage, brokerage fee, or contingent fee, other than bona fide employees working solely for the Contractor either directly or indirectly, and (b) that if this warranty is breached, the City may, at its option, terminate this Contract without penalty, liability or obligation, or may, at its option, deduct from any amounts owed to the Contractor under this Contract any portion of any such commission, percentage, brokerage, or contingent fee.

14.04 The Contractor covenants not to employ an employee of the City who performed work under a specific grant funded program covered by this Contract, in a job position with Contractor for which the former City employee would be performing the same grant funded program work for a period of one (1) year after the date of termination of this Contract without written City approval.

14.05 The Contractor shall provide a statement listing all political contributions and expenditures ("Statement of Political Contributions and Expenditures"), as defined by the Michigan Campaign Finance Act, MCL 169.201, et seq., made by the Contractor, its affiliates, subsidiaries, principals, officers, owners, directors, agents or assigns, to elective City officials within the previous four (4) years. Individuals shall also list any contributions or expenditures from their spouses.

14.06 The Contractor's Statement of Political Contributions and Expenditures shall be executed and made a part hereof. **This Contract is not valid unless and until the Statement of Political Contributions and Expenditures is provided.**

14.07 The Statement of Political Contributions and Expenditures shall be filed by the Contractor on an annual basis for the duration of the Contract, shall be current up to and including the date of its filing, and shall also be filed with all contract renewals and change orders, if any.

Article 15: Confidential Information

15.01 In order that the Contractor may effectively fulfill its covenants and obligations under this Contract, it may be necessary or desirable for the City to disclose confidential and proprietary information to the Contractor or its Associates pertaining to the City's past, present and future activities. Since it is difficult to separate confidential and proprietary information from that which is not, the Contractor shall regard, and shall instruct its Associates to regard, all information gained as confidential and such information shall not be disclosed to any organization or individual without the prior consent of the City. The above obligation shall not apply to information already in the public domain or information required to be disclosed by a court order.

15.02 The Contractor agrees to take appropriate action with respect to its Associates to ensure that the foregoing obligations of non-use and non-disclosure of confidential information shall be fully satisfied.

Article 16: Compliance with Laws

16.01 The Contractor shall comply with and shall require its Associates to comply with all applicable federal, state and local laws.

16.02 The Contractor shall hold the City harmless with respect to any damages arising from any violation of law by it or its Associates. The Contractor shall commit no trespass on any public or private property in performing any of the Services encompassed by this Contract. The Contractor shall require as part of any subcontract that the Subcontractor comply with all applicable laws and regulations.

Article 17: Office of Inspector General

17.01. In accordance with Section 2-106.6 of the City Charter, this Contract shall be voidable or rescindable at the discretion of the Mayor or Inspector General at any time if a Public Servant who is a party to the Contract has an interest in the Contract and fails to disclose such interest.

17.02. This Contract shall also be voidable or rescindable if a lobbyist or employee of the contracting party offers a prohibited gift, gratuity, honoraria or payment to a Public Servant in relation to the Contract.

17.03. A fine shall be assessed to the Contractor in the event of a violation of Section 2-106.6 of the City Charter. If applicable, the actions of the Contractor, and its representative lobbyist or employee, shall be referred to the appropriate prosecuting authorities.

17.04. Pursuant to Section 7.5-306 of the City Charter, the Inspector General shall investigate any Public Servant, City agency, program or official act, contractor and subcontractor providing goods and services to the City, business entity seeking contracts or certification of eligibility for City contracts and person seeking certification of eligibility for participation in any City program, either in response to a complaint or on the Inspector General's own initiative in order to detect and prevent waste, abuse, fraud and corruption.

17.05. In accordance with Section 7.5-310 of the City Charter, it shall be the duty of every Public Servant, contractor, subcontractor, and licensee of the City, and every applicant for certification of eligibility for a City contract or program, to cooperate with the Inspector General in any investigation pursuant to Article 7.5, Chapter 3 of the City Charter.

17.06. Any Public Servant who willfully and without justification or excuse obstructs an investigation of the Inspector General by withholding documents or testimony, is subject to forfeiture of office, discipline, debarment or any other applicable penalty.

17.07. As set forth in Section 7.5-308 of the City Charter, the Inspector General has a duty to report illegal acts. If the Inspector General has probable cause to believe that any Public Servant or any person doing or seeking to do business with the City has committed or is committing an illegal act, then the Inspector General shall promptly refer the matter to the appropriate prosecuting authorities.

Article 18: Amendments

18.01 The City may consider it in its best interest to change, modify or extend a covenant, term or condition of this Contract or require the Contractor to perform Additional Services that are not contained within the Scope of Services as set forth in Exhibit A. Any such change, addition, deletion, extension or modification of Services may require that the compensation paid to the Contractor by the City be proportionately adjusted, either increased or decreased, to reflect such modification. If the City and the Contractor mutually agree to any changes or modification of this Contract, the modification shall be incorporated into this Contract by written Amendment.

18.02 Compensation shall not be modified unless there is a corresponding modification in the Services sufficient to justify such an adjustment. If there is any dispute as to compensation, the Contractor shall continue to perform the Services under this Contract until the dispute is resolved.

18.03 No Amendment to this Contract shall be effective and binding upon the parties unless it expressly makes reference to this Contract, is in writing, is signed and acknowledged by duly authorized representatives of both parties, is approved by the appropriate City departments and the City Council, and is signed by the Chief Procurement Officer.

18.04 The City shall not be bound by Unauthorized Acts of its employees, agents, or representatives with regard to any dealings with the Contractor and any of its Associates.

Article 19: Fair Employment Practices

19.01 The Contractor shall comply with, and shall require any Subcontractor to comply with, all federal, state and local laws governing fair employment practices and equal employment opportunities.

19.02 The Contractor agrees that it shall, at the point in time it solicits any subcontract, notify the potential Subcontractor of their joint obligations relative to non-discrimination under this Contract, and shall include the provisions of this Article 19 in any subcontract, as well as provide the City a copy of any subcontract upon request.

19.03 Breach of the terms and conditions of this Article 19 shall constitute a material breach of this Contract and may be governed by the provisions of Article 11, "Default and Termination."

Article 20: Notices

20.01 All notices, consents, approvals, requests and other communications ("Notices") required or permitted under this Contract shall be given in writing, mailed by postage prepaid, certified or registered first-class mail, return receipt requested, and addressed as follows:

If to the Health Department on behalf of the City:

City of Detroit
Detroit Health Department
3245 East Jefferson, Suite 100
Detroit, MI 48207
Attention: Dr. Abdul El-Sayed, MD, DPhil, Executive Director & Health Officer

If to the Contractor:

SEMHA
3011 W. Grand Boulevard, Suite 200
Detroit, Michigan 48202
Attention: Mr. Gary Petroni, Executive Director

20.02 All Notices shall be deemed given on the day of mailing. Either party to this Contract may change its address for the receipt of Notices at any time by giving notice of the address change to the other party. Any Notice given by a party to this Contract must be signed by an authorized representative of such party.

20.03 The Contractor agrees that service of process at the address and in the manner specified in this Article 20 shall be sufficient to put the Contractor on notice of such action and waives any and all claims relative to such notice.

Article 21: Proprietary Rights and Indemnity

21.01 The Contractor shall not relinquish any proprietary rights in its intellectual property (copyright, patent, and trademark), trade secrets or confidential information as a result of the Services provided under this Contract. Any Work Product provided to the City under this Contract shall not include the Contractor's proprietary rights, except to the extent licensed to the City.

21.02 The City shall not relinquish any of its proprietary rights, including, but not limited to, its data, privileged or confidential information, or methods and procedures, as a result of the Services provided under this Contract.

21.03 The parties acknowledge that should the performance of this Contract result in the development of new proprietary and secret concepts, methods, techniques, processes, adaptations, discoveries, improvements and ideas ("Discoveries"), and to the extent said Discoveries do not include modifications, enhancements, configurations, translations, derivative works, and interfaces from the Contractor's intellectual property, trade secrets or confidential information, said Discoveries shall be deemed "Work(s) for Hire" and shall be promptly reported to the City and shall belong solely and exclusively to the City without regard to their origin, and the Contractor shall not, other than in the performance of this Contract, make use of or disclose said Discoveries to anyone. At the City's request, the Contractor shall execute all documents and papers and shall furnish all reasonable assistance requested in order to establish in the City all right, title and interest in said Discoveries or to enable the City to apply for United States patents or copyrights for said Discoveries, if the City elects to do so.

21.04 Any Work Product provided by the Contractor to the City under this Contract shall not be disclosed, published, copyrighted or patented, in whole or in part, by the Contractor. The right to the copyright or patent in such Work Product shall rest exclusively in the City. Further, the City shall have unrestricted and exclusive authority to publish, disclose, distribute and otherwise use, in whole or in part, any of the Work Product. If Work Product is prepared for publication, it shall carry the following notation on the front cover or title page: "This document was prepared for, and is the exclusive property of, the City of Detroit, Michigan, a municipal corporation."

21.05 The Contractor warrants that the performance of this Contract shall not infringe upon or violate any patent, copyright, trademark, trade secret or proprietary right of any third party. In the event of any legal action related to the above obligations of the Contractor filed by a third party against the City, the Contractor shall, at its sole expense, indemnify, defend and hold the City harmless against any loss, cost, expense or liability arising out of such claim, whether or not such claim is successful.

21.06 The making of payments, including partial payments by the City to the Contractor, shall vest in the City title to, and the right to take possession of, all Work Product produced by the Contractor up to the time of such payments, and the City shall have the right to use said Work Product for public purposes without further compensation to the Contractor or to any other person.

21.07 Upon the completion or other termination of this Contract, all finished or unfinished Work Product prepared by the Contractor shall, at the option of the City, become the City's sole and exclusive property whether or not in the Contractor's possession. Such Work Product shall be free from any claim or retention of rights on the part of the Contractor and shall promptly be delivered to the City upon the City's request. The City shall return all of the Contractor's property to it. The Contractor acknowledges that any intentional failure or unreasonable delay on its part to deliver the Work Product to the City will cause irreparable harm to the City not adequately

24.05 The headings of the sections of this Contract are for convenience only and shall not be used to construe or interpret the scope or intent of this Contract or in any way affect the same.

24.06 This Contract and all actions arising under it shall be governed by, subject to, and construed according to the law of the State of Michigan. The Contractor agrees, consents and submits to the exclusive personal jurisdiction of any state or federal court of competent jurisdiction in Wayne County, Michigan, for any action arising out of this Contract. The Contractor also agrees that it shall not commence any action against the City because of any matter whatsoever arising out of or relating to the validity, construction, interpretation and enforcement of this Contract in any state or federal court of competent jurisdiction other than one in Wayne County, Michigan.

24.07 If any Associate of the Contractor shall take any action that, if done by a party, would constitute a breach of this Contract, the same shall be deemed a breach by the Contractor.

24.08 The rights and remedies set forth in this Contract are not exclusive and are in addition to any of the rights or remedies provided by law or equity.

24.09 For purpose of the hold harmless and indemnity provisions contained in this Contract, the term "City" shall be deemed to include the City of Detroit and all other associated, affiliated, allied or subsidiary entities or commissions, now existing or subsequently created, and their officers, agents, representatives, and employees.

24.10 The Contractor covenants that it is not, and shall not become, in arrears to the City upon any contract, debt, or other obligation to the City including, without limitation, real property, personal property and income taxes, and water, sewage or other utility bills.

24.11 This Contract may be executed in any number of originals, any one of which shall be deemed an accurate representation of this Contract. Promptly after the execution of this Contract, the City shall provide a copy to the Contractor.

24.12 As used in this Contract, the singular shall include the plural, the plural shall include the singular, and a reference to either gender shall be applicable to both.

24.13 The rights and benefits under this Contract shall inure to the City of Detroit and its agents, successors, and assigns.

24.14 The City shall have the right to recover by setoff from any payment owed to the Contractor all delinquent withholding, income, corporate and property taxes owed to the City by the Contractor, any amounts owed to the City by the Contractor under this Contract or other contracts, and any other debt owed to the City by the Contractor.

(Signatures appear on next page)

EXHIBIT A: SCOPE OF SERVICES

I. Notice to Proceed

The term of this Contract shall begin on 10/01/2016 and shall terminate on 09/30/2018. The contract is contingent on continued funding by the Detroit Health Department or by Federal and State agency (ies). It is understood between parties that in the event of any interruption or delay in the continuation of this contract neither SEMHA nor the City of Detroit will incur any liability to the Provider.

II. Services to be Performed

Fiscal and Grant Administration Services

A. Fiduciary Services

Fiscal Management Services

- Prepare payrolls and vouchers for the reimbursement of service providers, program staff, program consultants, subcontractors, vendors, equipment, and supplies.
- Monitor each grant award to ensure that funds are sufficient to meet anticipated expenditures and to minimize the lapse of funds.
- Prepare and submit on a timely basis all reports required or approved by the City or the Grantor agency.
- Comply with all applicable federal and state requirements such as OMB Circulars covering cost principles, grant/agreement principles and audits in the performance of these fiduciary responsibilities. Indirect costs must be determined in accordance with requirements contained in 2 CFR 200.
- The Fiduciary shall assure that any equipment purchases supported in whole or in part by grant funding must be specified in an attachment to the program budget summary.
- The Fiduciary assures that all purchase transactions, whether negotiated or advertised, shall be conducted openly and competitively in accordance with the principles and requirements of 2 CFR 200.

Personnel Administration

- The Fiduciary shall designate an individual who shall serve as a liaison between the Fiduciary and the City regarding personnel issues.
- This individual shall hire, in accordance with Exhibit A, all personnel necessary for the proper administration of the grant funding.
- The Fiduciary shall ensure that all personnel shall devote such time, attention, skill, knowledge and professional ability as is necessary to most effectively and efficiently perform the services in conformance with the highest professional practices in the industry.

- The Fiduciary shall be responsible for all disciplinary action, including termination if necessary, of the Fiduciary's personnel assigned to this contract.

- The Fiduciary shall replace, immediately upon receipt of written notification, any of its personnel assigned to this contract, which in the City's reasonable opinion, unsatisfactorily performs. In all cases the Fiduciary shall supply a replacement that is acceptable to the City as soon as possible.

B. Grant Administration Services

Under the direction of the Executive Director and Public Health Officer, and on behalf of the Detroit Health Department, the firm(s) will provide fiduciary services for the following public health programs:

Children Special Health Services

Children's Special Health Care Services (CSHCS) provides specialty services to children with special needs and their families. CSHCS ensures that all children with special needs receive coordinated and ongoing comprehensive care; case management; private and/or public insurance (Medicaid/Medicare); early and continuous screening for special health care needs; vision and hearing screening; inpatient, emergency and outpatient hospital services, laboratory, X-rays and prescription drugs; durable medical equipment (DME), physical, speech and occupation therapy; and inpatient and outpatient mental health services.

Data to Care

Data to care is a public health strategy lead by health departments that uses HIV surveillance data to identify persons living with HIV (PLWH) who have never received medical care or need to be re-engaged in medical care. The data to care program works to reduce the number of new infections, increase access to care and improved health outcomes for PLWH and reduce HIV-related disparities and health inequities.

Environmental Health and Food Safety

Environmental Health responds to citizens' environmental concerns and complaints; conducts environmental health and safety inspections enforcing State of Michigan codes and regulations for adult foster care facilities and public swimming pools; and verifies that all codes and regulations are being met by local businesses by conducting general health inspections within the City.

Food Safety educates the community about safe food handling and storage and responds to restaurant complaints. This program also inspects, licenses, and reviews proposals to open small and large food businesses and temporary events serving food.

Hearing Screening

The hearing program provides free hearing screenings to all children in Detroit, ages 3-18 years old. Their trained staff conduct comprehensive screenings and works to make sure that Detroit's children are on track for healthy development.

HIV/STD Prevention

The HIV prevention program provides HIV prevention activities including: HIV testing, condom distribution; linkage to medical care; referral for prevention services, and referral to PrEP and other prevention services for individuals testing HIV positive.

Immunizations

The immunization program works to make immunization services accessible and increase the number of Detroit children who get needed vaccines on schedule. Detroit Health Department's Immunizations Program provides two Immunizations clinics that administer vaccines for both children and adults. The program also participates in the Vaccines for Children (VFC) Program, and conducts vaccine education and outreach in the community.

Lead Program

The goal of the Lead Prevention and Intervention Program is to prevent childhood lead poisoning, identify and treat exposed children, and reduce lead in the home. The Lead Program provides education to community members and professionals, case management, including home visits from advocates and nurses.

Local Maternal Child Health

The Local Maternal Child Health grant supports several Detroit Health Department programs focused on creating, implementing, and innovating with respect to policies, programs, and partnerships that create the circumstances in which every mother, infant and family has a chance at the healthiest possible life. Programs and services include: the Sisterfriends Detroit Birthing Project, infant safe sleep education, a fatherhood initiative, family nutrition education, developmental screening, oral health support, and long acting reversible contraceptives (LARCs).

Public Health Emergency Preparedness

The Office of Public Health Emergency Preparedness (OPHEP) manages preparedness and response activities in the event of a public health emergency to protect the health and wellness of people who live, work and play in the city of Detroit. OPHEP provides support for other emergencies such as natural disasters, terrorist attacks and technological events.

Ryan White Program

The Ryan White Program offers medical and support services to help people living with HIV. The Detroit Health Department partners with a network of hospitals, clinics, and nonprofit organizations with expertise in treating and caring for persons living with HIV. Program services include: HIV medical care; HIV medications; linkage to care/early intervention services; medical case management; assistance with applying for health insurance; medical transportation; emergency financial assistance; mental health counseling ; specialized services for previously incarcerated persons; and specialized services for women, children and youth.

Vision Screening

The Vision Program provides free vision screenings to all children in Detroit, ages 3-18 years old. Their trained staff conduct comprehensive screenings and work to make sure that Detroit's children are on track for healthy development.

Women, Infants and Children (WIC) Program

The Women, Infants and Children (WIC) Program is a special food and nutrition program for women, infants and children under age five. The goal of WIC is to promote good health through nutrition and education. It provides food, nutrition education, breastfeeding support, and referrals for health and other needs. Detroit Health Department WIC services are provided through department clinic, nonprofit organization, and clinical partner sites.

CITY OF DETROIT
AMENDMENT AGREEMENT NO. 6000468-1
TO CONTRACT NO. 6000468

THIS AMENDMENT AGREEMENT NO. is entered into by and between the City of Detroit, a Michigan municipal corporation, acting by and through its Health Department ("City"), and SOUTHEASTERN MICHIGAN HEALTH ASSOC, a MI Company, with its principal place of business located at 200 FISHER BLDG, DETROIT, MI, 48202-3011.

BASIC CONTRACT DETAILS:

X Amend Contract Amount:

Original Contract Amount is: $40,339,948.00
Amount Added to Contract is: $1,515,633.00
Total Amended Contract Value is: $41,855,581.00

WITNESSETH:

WHEREAS, the City has engaged the Contractor to provide certain services ("Services") to the City; and

WHEREAS, the City and the Contractor have entered into a Contract reflecting the terms and conditions governing the subject engagement; and

WHEREAS, Article 18 of the Contract permits the parties to amend the Contract by mutual agreement; and

WHEREAS, it is the mutual desire of the parties to amend the Contract as set out in detail in the following sections;

NOW, THEREFORE, in consideration of the foregoing, and of the benefits to accrue to the parties from this Amendment, the parties agree that this Contract is amended as follows:

1. **AMENDMENT TO EXHIBIT A**

1.01 Scope of Service, which now reads

Grant Administration Services

Immunizations

The immunization program works to make immunization services accessible and increase the number of Detroit children who get needed vaccines on schedule. Detroit Health Department's Immunizations Program provides two Immunizations clinics that administer vaccines for both children and adults. The program also participates in the Vaccines for Children (VFC) Program, and conducts vaccine education and outreach in the community.

Lead Program

The goal of the Lead Prevention and Intervention Program is to prevent childhood lead poisoning, identify and treat exposed children, and reduce lead in the home. The Lead Program provides education to community members and professionals, case management, including home visits from advocates and nurses.

Local Maternal Child Health

The Local Maternal Child Health grant supports several Detroit Health Department programs focused on creating, implementing, and innovating with respect to policies, programs, and partnerships that create the circumstances in which every mother, infant and family has a chance at the healthiest possible life. Programs and services include: the Sisterfriends Detroit Birthing Project, infant safe sleep education, a fatherhood initiative, family nutrition education, developmental screening, oral health support, and long acting reversible contraceptives (LARCs).

Public Health Emergency Preparedness

The Office of Public Health Emergency Preparedness (OPHEP) manages preparedness and response activities in the event of a public health emergency to protect the health and wellness of people who live, work and play in the city of Detroit. OPHEP provides support for other emergencies such as natural disasters, terrorist attacks and technological events.

Ryan White Program

The Ryan White Program offers medical and support services to help people living with HIV. The Detroit Health Department partners with a network of hospitals, clinics, and nonprofit organizations with expertise in treating and caring for persons living with HIV. Program services include: HIV medical care; HIV medications; linkage to care/early intervention services; medical case management; assistance with applying for health insurance; medical transportation; emergency financial assistance; mental health counseling ; specialized services for previously incarcerated persons; and specialized services for women, children and youth.

Vision Screening

The Vision Program provides free vision screenings to all children in Detroit, ages 3-18 years old. Their trained staff conduct comprehensive screenings and work to make sure that Detroit's children are on track for healthy development.

West Nile Virus Surveillance

Supports surveillance to ascertain the presence of Culex mosquito vectors and West Nile virus (WNV) in Detroit. Vector and pathogen surveillance will be conducted through the strategic placement of specialized mosquito traps in Detroit and the testing of captured mosquitoes for WNV.

$7,760.00

Zika Virus Community Support

Project focuses on mosquito-borne disease community interventions to limit and prevent the spread of Zika virus within Detroit. These interventions include, but are not limited to, community education, the production of communications materials, and breeding site reduction.

$9,700.00

Zika Virus Mosquito Surveillance

Supports surveillance to ascertain the presence of Aedes mosquito vectors and Zika virus in Detroit. Vector and pathogen surveillance will be conducted through the strategic placement of specialized mosquito traps in Detroit and the testing of captured mosquitoes for Zika virus

$9,700.00

2. AMENDMENT TO EXHIBIT B:

2.01 Exhibit B, which now reads:

Original Contract Amount: **$40,339,948.00**

Is amended to read for agreed procedures:

Amended Contract Amount: **$41,855,581.00**

3. EFFECT OF AMENDED TERMS ON THE REMAINING PROVISIONS OF THE CONTRACT

3.01 With the exception of the provisions of the Contract specifically contained in this Amendment, all other terms, conditions and covenants contained in the Contract shall remain in full force and effect and as set forth in the Contract.

City of Detroit:
Health Department:

By: DocuSigned by: Timothy Lawther 9/11/2017
Name Date

Chief Operating Officer - Health
Title

Contractor:

By: DocuSigned by: Gary Petroni 4/11/2017
Name Date

Executive Director
Title

THIS AMENDMENT WAS APPROVED BY THE CITY COUNCIL ON:

9/12/17
Date

THIS AMENDMENT WAS APPROVED BY FRC ON:
(if FRC approval is not required, leave blank)

9/25/17
Date

APPROVED BY LAW DEPARTMENT PURSUANT TO § 7.5-206 OF THE CHARTER OF THE CITY OF DETROIT

DocuSigned by: Boysie Jackson 9/26/2017
Corporation Counsel Date

APPROVED BY THE CHIEF PROCUREMENT OFFICER

8/3/17
Chief Procurement Officer Date

THIS CONTRACT AMENDMENT IS NOT VALID OR AUTHORIZED UNTIL APPROVED BY RESOLUTION OF THE CITY COUNCIL AND SIGNED BY THE CHIEF PROCUREMENT OFFICER.

CITY OF DETROIT
AMENDMENT AGREEMENT NO. 6000468
TO CONTRACT NO. 6000468-2

THIS AMENDMENT AGREEMENT NO. 2 is entered into by and between the City of Detroit, a Michigan municipal corporation, acting by and through it Health Department ("City"), and Southeastern Michigan Health Association, a Michigan Corporation, with its principal place of business located at 3011 W. Grand Blvd. Suite 200 Fisher Bldg. Detroit, MI 48202.

BASIC CONTRACT DETAILS:
X **Amend Contract Duration:**
Original Contract Expiration Date: 9/30/2018
Current Expiration Date: 2/28/2019

WITNESSETH:

WHEREAS, the City has engaged the Contractor to provide certain services ("Services") to the City; and

WHEREAS, the City and the Contractor have entered into a Contract reflecting the terms and conditions governing the subject engagement; and

WHEREAS, Article 18 of the Contract permits the parties to amend the Contract by mutual agreement; and

WHEREAS, it is the mutual desire of the parties to amend the Contract as set out in detail in the following sections;

NOW, THEREFORE, in consideration of the foregoing, and of the benefits to accrue to the parties from this Amendment, the parties agree that this Contract is amended as follows:

1. **AMENDMENT(S) TO EXHIBIT A**

1.01 Exhibit A which now reads:

This Contract shall be approved by the required City departments, approved by the City Council, and signed by the City's Chief Procurement Officer. The effective date of this Contract shall be the date upon which the Contract has been authorized by resolution of the City Council. The term of this Contract shall terminate on **September 30, 2018.**

Signature Page

The City and the Contractor, by and through their duly authorized officers and representatives, have executed this Contract Amendment as follows:

City of Detroit:
Health Department:

By: DocuSigned by: Timothy Lawther 9/11/2018
4C67D7CD241A495...
Name Date

Deputy Director - Health
Title

Contractor:

By DocuSigned by: Gary Petroni 9/11/2018
7C78D4C70CA4473...
Name Date

Executive Director
Title

THIS AMENDMENT WAS APPROVED BY THE CITY COUNCIL ON:

October 16, 2018
Date

THIS AMENDMENT WAS APPROVED BY FRC ON:
(if FRC approval is not required, leave blank)

Date

APPROVED BY LAW DEPARTMENT PURSUANT TO § 7.5-206 OF THE CHARTER OF THE CITY OF DETROIT

September 20, 2018
Corporation Counsel Date

APPROVED BY THE CHIEF PROCUREMENT OFFICER

DocuSigned by: Boysie Jackson 10/17/2018
Chief Procurement Officer Date

THIS CONTRACT AMENDMENT IS NOT VALID OR AUTHORIZED UNTIL APPROVED BY RESOLUTION OF THE CITY COUNCIL AND SIGNED BY THE CHIEF PROCUREMENT OFFICER.

Final amendment

Contract Purchase Agreement : 6000468 Change Order : 10
Date : 09/10/2019

CITY of DETROIT

To :

Company	SOUTHEASTERN MICHIGAN HEALTH ASSOC
Contact	JEREMY ANDREWS
Address	3011 WEST GRAND BLVD SUITE 200 FISHER BLDG DETROIT, MI 48202

From :

Company	City of Detroit
Contact	Michael Anderson
Address	2 WOODWARD AVENUE STE 1100 DETROIT, MI 48226 UNITED STATES
Phone	
Fax	
E-mail	andersonmi@detroitmi.gov

This amendment supersedes the agreement 6000468 and all its prior modifications.

Amd 4 approved by CC week of 8/26/19. Amd 4 adds $7,304,347.71 onto CPA. New total of CPA is $55,043,911.29. Also extending time to 12/31/19.

This contract modification is effective as of **09/10/2019**.

Chief Procurement Officer

Boyzie Jackson

GENERAL CONDITIONS
Last Updated April 7, 2017

1. **PROCUREMENT POLICY**
Procurement for the City of Detroit shall be carried out in a manner which provides a transparent, open, and fair opportunity for all eligible Suppliers to participate. This bid shall be made without collusion with any other person, firm or corporation making any bid or proposal, or who otherwise makes a bid or proposal.

Suppliers must have a valid contract or Purchase Order with the signature of the Chief Procurement Officer to receive payment for goods or services rendered. Suppliers who perform work without a valid contract or purchase order will not be paid.

2. **QUOTATIONS/PROPOSALS**
Suppliers MUST electronically submit the bid quotation/proposal. Failure to submit will be grounds for rejection. In your quotation, a distinction between dollars and cents must be made. Illegible bids may be grounds for rejection of your bid.

3. **RESPONSIBILITIES**
The responsibilities under this (proposed) contract are that the City of Detroit is obligated during the period stipulated to purchase all its NORMAL REQUIREMENTS of the above referenced products and/or services from the Supplier, and the Supplier is obligated to supply the quantities and/or services which the City of Detroit requires for its operations. Requirements stated herein are approximate but are for entire normal requirements, whether more or less. Requirements stated are not guaranteed.

4. **COMPLIANCE WITH LAWS AND SECURITY REGULATIONS**
The Supplier shall fully comply with and shall require its associates to comply with: (1) federal, state and local laws, ordinances, code(s), regulations and policies applicable to this contract, including, but not limited to, all security regulations in effect from time to time on the City's premises; (2) codes and regulations for materials, belonging to the City or developed in relationship to this project; and (3) with the terms and conditions of the grant, and the requirements of the grantor agencies when grant funds that are specifically related to this Contract are expended.

The Supplier shall indemnify, defend, and hold the City harmless with respect to any damages arising from any violations of applicable laws and regulations by it or its associates. The Supplier shall commit no trespass on any public or private property in performing any of the Services encompassed by this Contract. The Supplier shall require, as part of any subcontract that sub-Contractors comply with all applicable laws and regulations. The Supplier shall secure, at no extra cost to the City of Detroit, all Permits and Licenses necessary for the performance of the work and shall fully comply with all their terms and conditions.

5. **EQUAL OPPORTUNITY**
It is the policy of the City that women-owned businesses (WBE), minority-owned businesses (MBE), and certified Detroit businesses (DB) have a fair and equal opportunity to participate in the City's purchasing process. Therefore, the City of Detroit strongly encourages D/M/WBEs to compete for contracts, as well as encourage suppliers to hire D/M/WBEs as subcontractors to supply goods and/or services. The City of Detroit supports a robust free market system that seeks to include viable business and provides opportunity for business growth and development.

6. **INSURANCE**
The Supplier shall maintain, at a minimum and at its expense during the term of this contract, the following insurance:

i. Worker's Compensation insurance with Michigan statutory limits and Employer's Liability insurance with limits of $500,000.00 each accident, $500,000.00 each disease, $500,000.00 each employee. For Federal and State Funded Training Programs, the Supplier is required to secure worker's compensation insurance for all of its participants.

ii. Commercial General Liability insurance with limits of $1,000,000.00 per occurrence, subject to a minimum aggregate limit of $2,000,000.00

iii. Automobile Liability insurance covering all owned, hired and non-owned vehicles with personal protection insurance and property protection insurance to comply with the provisions of the Michigan No-Fault Insurance Act, including residual liability insurance with a minimum combined single limit of $1,000,000.00. Include MCS90 endorsement (if hazardous waste will be transported by vendor's auto) with minimum property damage limits of $1,000,000.00 each occurrence.

Handicappers Civil Rights Act, as amended. The Detroit Human Rights Department, The Detroit Human Rights Commission, the Michigan Department of Civil Rights and the Michigan Civil Rights Commission by mutual agreement, have authorized the Detroit Human Rights Department in a contract compliance program to monitor all Suppliers doing business with the City and to review the employment practices of Suppliers seeking to do business with the City prior to entering into a contract so that the mandates of Section 209 of the Michigan Civil Rights Act are carried out. The Supplier agrees to include this paragraph number 3 in any subcontract. Breach of this covenant may be regarded as a material breach of the contract.

12. **UNIT PRICES, NOTATIONS, AND WORKMANSHIP**
Prices and notations must be typed or in ink. Prices shall be for new items only unless specified otherwise in this Bid Response Document. No erasures or "white-outs" are permitted. Mistakes may be crossed out and corrections entered and initialed in ink by the persons signing the bid document. Unit prices shall be stated based on units specified. The Supplier may quote on all or a portion of a quantity as specified. Quote on each item separately and indicate brand name or make. All materials furnished must be new, of latest model and standard first-grade quality, of best workmanship and design, unless expressly specified.

13. **PRICES QUOTED**
Prices quoted must be net of discounts. Discounts will be considered in the determination of best value Supplier, provided discounts correspond for the duration of the contract. Where net is equal to bid with discount deducted, award will be made to the net bid. The Supplier shall extend and total the bids.

14. **SALES TAX EXEMPTION**
The City is exempt from sales tax on those articles which the City buys for its own use. Articles bought by the Supplier and incorporated into other products are taxable to the Supplier. Such tax should be included in the price and will not be paid as an extra by the City. Sales tax is excluded from incorporated products when the final product is sold to non-profit housing projects.

15. **SPECIFICATIONS, CHANGE OF SPECIFICATION, AND ERRORS OR OMISSION**
Specifications which refer to brand names are given for reference. Suppliers may quote on equivalent articles, provided that brand name and catalog number(s) and any deviations are noted on the bid form and complete descriptive literature is furnished. Exceptions will state "Do Not Substitute." The decision of the City shall be final. If any of the terms and conditions prevent you from bidding, or if you wish to request revisions of specifications, or a change in quantity which will result in lower unit cost to the City, or get an interpretation, your request will receive consideration if presented to the City as much in advance of bid submission deadline as possible. If any change is found desirable while the bid is current, the City will notify the Suppliers of the bid revision electronically and if required extend bid submission date. Suppliers are not permitted to take advantage of any errors or omissions in specifications since full instructions will be given should they be discovered before bid submission date.

Specifications referred to herein are used to indicate desired type, and/or construction, and/or operation. Other products and/or services may be offered if deviations from specifications are minor and if all deviations are properly outlined and stated in the bid document. Failure to outline all deviations will be grounds for rejection of your bid.

The decision of the City of Detroit, acting through the Chief Procurement Officer, shall be final as to what constitutes acceptable deviations from specifications.

16. **RECEIPT OF BIDS**
Bids must be received by the Office of Contracting and Procurement through the electronic bid system (e.g. BidSync) prior to the date and time specified on the face of this bid package unless otherwise authorized. Late bids cannot be accepted except in extenuating circumstance such as Bid Sync system failure. The responsibility of getting bids to the Office of Contracting and Procurement on time rests entirely with the Supplier.

17. **WITHDRAWAL**
No bid shall be withdrawn for (90) ninety days from submission deadline unless otherwise stated in this bid form. Suppliers may reduce this period if stated on bid, but such bids may be rejected on the basis of the reduced time period.

18. **AWARD CONDITIONS**
The City reserves the unqualified right to award by item(s) unless otherwise stipulated, to waive any irregularity in any bid or to reject any and all bids when, in the judgment of the City, the best interest of the City will be served.

The award of a Contract will not be made to any Supplier who is in arrears in City taxes. Article V, Chapter 18 of the Detroit City Code, forbids the award of any contract to person(s) who are in arrears of City real estate, personal property and/or income taxes. To ensure compliance with the above ordinance, Suppliers may check the City of Detroit website, www.detroitmi.gov. All awards will be made in accordance with the provisions of Article V, Chapter 18 of the Detroit City Code which provides for purchasing and disposition of property consistent with the City Charter.

upon 72 hours' notice. The Supplier shall permit the authorized representative of the City to inspect and audit all data and records of the Supplier relating to its performance under this Contract during the term of the Contract and for three (3) years after final payment. All records relating to this Contract shall be retained by the Supplier during the term of the Contract and for three (3) years after final payment for the purpose of such audit and inspection.

29. INDEMNITY

The Supplier agrees to indemnify, defend, and hold the City harmless against and from any and all liabilities, obligations, damages, penalties, claims costs, charges, losses and expenses (including without limitation, fees and expenses for attorneys, expert witnesses and other consultants), which may be imposed upon, incurred by or asserted against the City by reason of any negligent or tortious acts, errors, or omissions attributable to the Supplier, or any failure by the Supplier to perform its contractual obligations during the term of this Contract. This provision shall apply to all matters whether litigated or not, and shall include disputes between the Supplier, the City of Detroit, and any negligent or tortious acts, errors, or omissions attributable to the Supplier, its sub-Contractors or Agents.

30. CONFLICT OF INTEREST

The Supplier covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which could conflict in any manner or degree with the performance of the services under this Contract. The Supplier further covenants that in the performance of this Contract no person having any such interest shall be employed. The Supplier further covenants that no officer, agent, or employee of the City and no other public official who exercise any functions or responsibilities in the review or approval of the undertaking or carrying out of this Contract has any personal or financial interest, direct or indirect, in this Contract or in the proceeds thereof via corporate entity, partnership, or otherwise. The Supplier also hereby warrants that it will not and has not employed any person to solicit or secure this Contract upon any agreement or arrangement for payment of a commission, percentage, brokerage, contingent fee, other than bona fide employees working solely for the Supplier either directly or indirectly, and that if this Warranty is breached, the City may, at its option, terminate this Contract without penalty, liability or obligation, or may, at its election, deduct from any amounts owed to the Supplier hereunder, any amounts of any such commission, percentage, brokerage, or contingent fee.

In accordance with Section 4-122 of the Detroit City Charter, the contractor shall provide a statement listing all political contributions and expenditures ("Statement of Political Contributions and Expenditures"), as defined by the Michigan Campaign Finance Act, MCL 169.201, et seq., made by the contractor, its affiliates, subsidiaries, principals, officers, owners, directors, agents or assigns, to elective City officials within the previous four (4) years. Individuals shall also list any contributions or expenditures from their spouses. The Contract is not valid unless and until the Statement of Political Contributions and Expenditures is provided. The Statement of Political Contributions and Expenditures shall be filed by the contractor on an annual basis for the duration of the Contract, shall be current up to and including the date of its filing, and shall also be filed with all contract renewals and change orders, if any.

31. CHANGE IN SUPPLIER INFORMATION

Supplier shall notify the Office of Contracting and Procurement upon any change of address, telephone number, facsimile number and electronic mail address, where applicable, within five (5) business days of such change. The notice shall be submitted in writing to procurementinthecloud@detroitmi.gov identified on the Purchase Order and shall include all of Supplier's changed information and the effective date of such change.

32. TAXPAYER IDENTIFICATION NUMBER

Supplier shall notify the Chief Procurement Officer and the Income Tax Administrator of the City upon the change of Supplier's taxpayer identification number. Such notification shall be in writing; shall include at a minimum, the Supplier's taxpayer identification number in use by the City, Supplier's new taxpayer identification number and all contract and purchase order numbers under which the Supplier is currently providing goods and services to the City; and, shall be electronically submitted to the City within five (5) business days of Supplier's receipt of confirmation of the registration of the new taxpayer identification number by the Internal Revenue Service. Failure of the Supplier to supply the information required, may be deemed and event of default at the sole discretion of the City.

33. SETOFF

In addition to Supplier's obligation to not become in arrears to the City for any obligation owed to the City, City shall have the right to recover from payment owed to Supplier by City, delinquent withholding, corporate and property tax liabilities owed to the City by Supplier. The City's right of recovery shall be a setoff against those payments owing to Supplier by virtue of this, or any current City Contract. The City will provide written notice to Supplier of any intention to invoke its right to setoff payments due to Supplier under this Contract against delinquent withholding, corporate and property tax liabilities owed. Such written notice shall be delivered to Supplier at the address provided in the Contract/Purchase Order.

34. SUPPLIER COMMITMENT

By submitting this bid or proposal, the Supplier commits and legally binds itself to provide to the City of Detroit the goods/services in this bid at the time, place, manner and pricing set forth in the bid as accepted by the City.

Attachment 8A

Michigan Department of Health and Human Services (MDHHS)
Bureau of Family, Maternal and Child Health
Division of Family and Community Health

LOCAL MATERNAL CHILD HEALTH GRANT PROGRAM COMMUNITY PLAN
FY 2016 (10/1/2015 – 9/30/2016)

The Local Maternal Child Health (LMCH) grants are funded with the Federal Title V allocation to the State of Michigan. Historically, these funds were flexible in how they could be used to address locally identified health needs of women and children in the jurisdiction. It was expected that each local health department would use a defined needs assessment to determine and identify its jurisdiction's MCH needs.

For FY 2016 Michigan Department of Health and Human Services (MDHHS) will be making several changes to the requirements of the Local Maternal Child Health (LMCH) Program. As explained in the June 22, 2015 memo from Michigan's Maternal Child Health Director Rashmi Travis, Michigan must make modifications to comply with the changing Federal requirements, one of which is a requirement that the designated national and state performance measures must be addressed, see Attachment C. However, as explained in MCH Director Travis's memo, this will be a year of phase-in transition to bring us into alignment. We will not require that these funds be solely spent on the national and state performance measures in FY 16, but we will need you to identify where your local objectives and work plans already align with the measures and where they do not.

Please review the new mandatory Maternal Child Health (MCH) national and state performance measures [See Appendix C]. In revised directions for this fiscal year, we are asking local health departments to attempt to focus on the new national and state performance measures to the extent possible for developing planned use of these funds. In addition to the local needs assessments directing the use of MCH funds, local health departments are asked to examine each of the eight national and state performance measures and to identify in your plan the measure(s) to be addressed in the locally identified MCH priorities and planned activities.

During an MDHHS annual audit of the Title V grant, areas of exception were identified relating to preventive and primary care for children. Title V regulations require that States budget at least 30 percent of their federal allocation for preventive and primary care for children [Sec 505 (a)(3)(A)]. The audit noted that there must be a way for MDHHS to separately distinguish direct services to children and to women in the budget. There was also an incorrect allocation of outreach services for children. **Please note: outreach efforts directed for children services are NOT considered preventive or primary care for children and cannot be counted as such.** There must be a separation of preventive and primary care for children from outreach services. Outreach services are to be reported under "Enabling Services Children - MCH."

Categories used to report projects for LMCH in the Electronic Grants Administration and Management System (EGrAMS/MI E-Grants are new again this year. There are three levels of service using the terms and definitions from the federal guidelines and specified by populations, children or women. While not new, see the definitions for direct services, enabling services and public health services and systems, in Attachment D Title V MCH Services Glossary. Program specific reporting categories for Family Planning, Immunizations and Maternal Infant Health Program (MIHP) by the population groups, women, adolescents (Family Planning only) or children remain to identify these specific services.

The budget categories for this year are as follows:

- Direct Services Children – MCH
- Enabling Services Children – MCH
- Direct Services Women – MCH
- Enabling Services Women – MCH
- Public Health Functions & Infrastructure - MCH
- Children's Special Health Care Services – MCH
- Family Planning – Adolescents – MCH
- Family Planning – Women – MCH
- Immunizations – Children – MCH
- Immunization – Women – MCH
- Maternal Infant Health Program (MIHP) – Women – MCH
- Maternal Infant Health Program (MIHP) – Children – MCH

Continuing from last year, you can no longer budget the LMCH grant fund distribution in projects that have state allocations such as Immunization, Family Planning, etc. LMCH funding needs to be budgeted separately.

This plan format requires narrative information answering questions 1 through 6. Sufficient information should be provided to clearly outline the Local Maternal Child Health Grant Program Community Plan and to include identification of which national or state performance measure is being addressed.

State and county natality and mortality data through 2013 (with some preliminary 2014 infant mortality and natality data) is available on the MDCH website, which may help in the information requested in the plan. ***The website address is www.michigan.gov/mdhhs at the bottom of the page see the scrolling choices of Special Programs; click on "Vital Records – Birth Death, Marriage, Divorce;" then click "Statistics and Reports;" "Vital Statistics;" and make your choices from there.***

If you choose to use at least a portion of your MCH funds to support childhood lead screening conducted within the Women, Infants and Children (WIC) Program, identify this as lead screening under "Direct Services Children - MCH" in MI E-Grants, not in the WIC project element.

A local health department can choose to use a portion of their MCH grant allocation for a MCH focused community assessment in order to assist in the identification of priority MCH needs under the Public Health Functions & Infrastructure - MCH project element in MI E-Grants. It would be expected that the LHD would utilize data from the needs assessment to help establish new and continuing priorities. Future MCH Plans would allocate LMCH funds to work on the identified priorities.

Michigan legislation mandates the reporting of the actual number of women, children and adolescents served and amounts expended for each group with LMCH grant funds. For the purposes of reporting in this plan, children are 0-9 years of age, adolescents are 10-19 years of age and childbearing women are 20 – 44 years.

If a local health department chooses to use these funds to support a home visiting program, it must comply with Michigan's law Public Act 291 of 2012 (http://www.michigan.gov/documents/homevisiting/2012-PA-0291_434967_7.pdf). This law requires that all Michigan's funding for home visiting go to support evidence-based or promising programs. For more information, visit the home visiting web: (http://www.michigan.gov/homevisiting/0,5450,7-314-66229_69229_69233-332209--,00.html). **There are a variety of requirements involved with meeting all**

of the requirements for home visiting. MDHHS will provide detailed technical assistance about using funds allocated by the state for home visiting during FY 16.

The plan is due when the budget application is due. Please provide your agency finance person with an electronic copy of the FY 16 LMCH Grant Program Community Plan and have them submitted as an attachment electronically in MI E-Grants with budgets. If your agency uses MCH grant funds in multiple program elements, please have finance submit the attachment to the project that has the highest LMCH allocation.

If you have questions regarding the LMCH Grant Program Community Plan or submission via MI E-Grants, please contact Robin Orsborn, LMCH Consultant, at orsbornr@michigan.gov or 517-335-8976.

LOCAL MATERNAL CHILD HEALTH (MCH) GRANT PROGRAM COMMUNITY PLAN: FY 2016 (10/1/15 – 9/30/16)
(Please attach to MI E-Grants – on a detailed budget line of your choice.)

ATTACHMENT B

Local Health Department Name: Detroit Department of Health and Wellness Promotion (DHWP)

Contact for additional information on this plan, if needed: Chelsea Harmell

Name: Chelsea Harmell, Maternal Health Program Manager
Email: HarmellC@detroitmi.gov
Telephone: (313) 410-5344

Local MCH Plan for FY 2016:

1. What are the priority MCH needs identified for the community for FY 2015/2016? Please describe data collected and analyzed in identifying these needs. Provide local health department data, client survey or focus group data and data trends, as appropriate.

Detroit had 10,081 births in 2012 and 151 of those infants died before their first birthday. For 2011-2013 Detroit had an average infant mortality rate (IMR) of 13.6+/- 1.3 infant deaths per 1000 live births according to Michigan Vital Statistics. Detroit's IMR remains about twice the state and national rate. The average black infant mortality rate was even higher at 14.8 for the same years.

Detroit has experienced some of the improvements in birth outcomes that have been seen statewide and nationally. Taking a deeper dive into the experience of the community, we unpeel the complexity of the multi-layered metric of infant mortality. Detroit's black infant mortality rate (IMR) has varied over time: going from 16.1 in 2007 to 14 in 2011, and up again to 16 in 2012. Detroit's IMR is well above Michigan's black IMR of 13.5 in 2012, and the U.S. black IMR of 11.4 in 2011 (most recent available data). Reviewing the reference population of white infant deaths, Detroit's white IMR goes from 7.1 in 2007 to an asterisk yes*) in 2011, because there were so few infant deaths (5) in the city's white population. White IMR in 2012 is reported as 15.7 [1] This trend is inconsistent with the state white infant mortality rate at 5.5 and the U.S. rate at 5.1 (2011), which highlights the need to better understand the "Detroit Phenomena" that adversely impacts birth outcomes for Detroit mothers. Detroit is the largest city in Wayne County. The 2014 County Health Rankings ranked Wayne County 82 out of 82 for health outcomes and 81 out of 82 for length of life.[2]

Detroit has a low birth weight rate (less than 2500 grams) of 137.5 per 1000 live births as compared to Wayne County, excluding Detroit at 83.1 and the state of Michigan at 84.6. Preterm birth is the leading cause of perinatal morbidity and infant mortality. In Detroit 1 in 6 live births are preterm or 17.6%, which has been unchanged since 2001. Additionally, Detroit's black preterm birth rate is 18.7%, and the

[1] Michigan Vital Statistic, Michigan Department of Community Health, September, 2014
[2] Robert Wood Johnson Foundation, countyhealthrankings.org

white preterm birth rate is 13.3% -- both exceed the states' preterm birth rate of 12% and the Healthy People 2020 goal of 11.4%.

Detroit had the third highest sleep-related death rate in the state at 2.7 and from 2010-2013 110 Detroit babies died from sleep related causes (MPHI, Infant Safe Sleep Forum). Preliminary data for 2015 shows that this year may be the worst year on record for the city if trends continue (MDHHS preliminary data). The sleep-related death rate is three times as high for African American babies in Michigan as for white babies according to the latest MPHI report analyzing data from 2010-2012.

In 2012 Detroit had over half of the state's cases of lead poisoning and ten Detroit zip codes had elevated blood lead level (EBLL) rates of over 2% (MDCH Annual Data Report on Blood Lead Levels, 2012). Among the 43% of Detroit children under age 6 who were tested for lead poisoning in 2012, more than 10% had EBLL rates of at least 5 ug/dL (8.5% had blood lead levels of at least 5ug/dL and 1.6% had blood lead levels of at least 10 ug/dL) (MDCH Annual Data Report on Blood Lead Levels, 2012).

2. Describe any health disparities[1] related to the MCH population noted in your community needs assessment. What are the priority MCH needs identified by your department for FY 2015/2016 related to these health disparities?

For the priority areas noted for Detroit, all disproportionately impact African American residents as compared to white residents. Notably, Detroit's population of 698,582 persons, as estimated by the census bureau for 2012, is 82.7% black and 10.6 % white. Twenty-six point seven percent (26.7%) of the residents are under 18 years of age, and approximately 77% are high school graduates. The over representation of African Americans in Detroit is further impacted by the following census bureau data that demonstrates the racial disparities in not only health but wealth, income and quality of life. The median value of owner occupied housing in Detroit is $59,700 compared to $128,600 in Michigan. Per capita income in Detroit in the past 12 months/for 2012 is $14,861 vs. $25,547 for Michigan. Median household income is $26,955 vs. $48,471 for Michigan. Percentage of Detroit persons living below the poverty level is 38.1% vs. 16.3 for the state. Additionally, retail sales per capita in Detroit are $3,567 compared to $10,855 in Michigan, and persons per square mile in Detroit is 5,144 compared to Michigan at 175 for Michigan's population is 79% white and 14% black.

Detroit's majority African American population has a higher than state and U.S. rate (which can be a proxy for the white rate) of infant mortality, low birth weight, preterm birth, overweight/obesity and STD rate; and a lower than Michigan rate for dental care (women and children), up to date immunizations, early entry to prenatal care, breastfeeding, and interconception care – particularly for care of chronic conditions. DHWP identifies all of these areas as priority needs, recognizing that preterm birth and low birth weight are the major causes of infant death in Detroit. Other identified priority needs are in some way related to preventing preterm birth with the exception of improving immunization rates, which will help to improve the overall health of the community and promote the "wellness" culture of preventive health care.

3. Which national performance measure(s) and state performance measures (see Appendix C) will be addressed based on the MCH priorities identified in question 1 above?
   The following National Performance Measures (NPM) will be addressed:
   1) Well-Woman Visit: % of women with a past year preventive medical visit
   4) Breastfeeding: A. % infants who are ever breastfed and B. % of infants breastfed exclusively through 6 months
   13) Oral Health: B. % of children, ages 1-17 who had a preventive dental visit in the past year
   The following State Performance Measures (SPM) will be addressed:
   S1) Lead prevention
   S2) Safe Sleep Environments
   S3) Depression across the life course
   S4) Provision of medical services and treatment for children with special health care needs

4 What interventions will be used to address these priority MCH needs, and national and state performance measures identified in questions 1, 2 and 3? Has your department established a timeframe to achieve the rate for the identified need(s)?

NPM 1) Well-Woman Visit: % of women with a past year preventive medical visit

DHWP is teaming up with CityMatCH and University of Illinois-Chicago to implement the Well Woman Project, aimed at assessing needs and developing a strategy to increase the number of women who make and keep their Well-Woman Visits each year. Recruitment will begin in January 2016 and the listening sessions will be held in March 2016. DHWP will utilize LMCH funds host at least two Detroit listening sessions, a call-in number for women to leave messages about their experiences, and a blog where women can share their stories so that in FY17 DHWP can launch a new local data-driven Well-Woman Initiative to improve pre- and interconception care by screening for breast and cervical cancers, testing for STDs/STIs, screening for intimate partner violence and mental health conditions, and assessing family planning needs. In addition, DHWP's five key maternal infant health message campaign (formerly *Detroit Baby)* will encourage women to find a medical home and to keep their post-partum visits after delivery to ensure continuity of pre- and interconception care. A 1.0 Maternal Health Program Manager, .5 FTE community health educator and intern will support the work of the projects.

NPM 4) Breastfeeding: A. % infants who are ever breastfed and B. % of infants breastfed exclusively through 6 months

DHWP will use LMCH funds to promote breastfeeding through the 5 key PPOR-driven messages including: "*Breastfeed: Mommy Milk is magic."* As a co-lead for the Detroit Institute for Equity in Birth Outcomes (DIEBO), DHWP will also implement two downstream initiatives aimed at 1) promoting the First Friendly Food System (Kellogg-funded initiative to increase community awareness and support of breastfeeding in Detroit) and 2) working to make all Detroit hospitals Baby-Friendly by supporting technical assistance, training, and providing materials for hospital providers and community partners through a collective impact model utilizing Coffective technology and shared messaging across Detroit's perinatal system beginning in October 2015. Baby-Friendly hospitals encourage breastfeeding by providing intensive education to all pregnant

women on the benefits of breastfeeding, promoting skin to skin contact after delivery and postpartum, encouraging breastfeeding within the first hour of birth, encouraging 24-hour rooming-in, providing breastfeeding babies with no supplements unless medically stated, and linking women to breastfeeding support. St. John was Detroit's first Baby-Friendly Hospital and saw its breastfeeding rates increase from 55% in 2011 to 80% in 2014 after becoming Baby-Friendly. DHWP is working closely with DIEBO, the Perinatal to Pediatric Think Tank (P2P), and St. John's Breastfeeding Coordinator Dr. Paula Schreck to help DMC and Henry Ford Health System become Baby-Friendly and increase breastfeeding rates, particularly among African American women. In addition, DHWP will continue to partner Safe Sleep Efforts with Breastfeeding efforts by promoting dual education in community classes, outreach events, and breastfeeding support groups. These efforts will be supported in part by 2.0 FTE program managers, a .5 FTE community health educator, interns, and the collective impact of DIEBO.

NPM 13) Oral Health: B. % of children, ages 1-17 who had a preventive dental visit in the past year

DHWP will use LMCH funds to improve linkages to pediatric dental care for families who are either uninsured or underinsured by contracting with Michigan Community Dental Clinics to provide preventive and emergency dental care to children ages 1-17. The MCDC clinic will operate out of an existing DHWP WIC and Immunizations clinic to create a "one-stop shop" that enhances referrals and convenience for families. Efforts to increase awareness of the importance of pediatric and adult dental care will be supported by a 1.0 social worker. The social worker will work to link Detroit families to appropriate community resources, including pediatric dental care, immunizations, WIC, breastfeeding support, safe sleep education, prenatal care, evidence-based home visiting, housing assistance, and more. Funding will also support transportation costs for dental outreach and to help families without access to transportation make their dental appointments.

SPM S1) Lead Prevention

DHWP will enhance its lead prevention and intervention capacity by using LMCH funds to support 3.2 FTE Lead Health Advocates and .67 FTE Registered Nurse positions dedicated to providing community environmental health risk education, linkages to care, and screening for elevated blood lead levels. Health advocates will educate Detroit families at outreach events and in-home assessments, and will provide follow up to ensure that children who have had elevated blood levels are linked to care and that measures are taken to either relocate families or make their homes safer. LMCH funds will also support 12-15 lead home inspections.

SPM S2) Safe Sleep Environments

DHWP will utilize efforts of a .5 FTE community health educator (.5 FTE appointed to Safe Sleep Mini-Grant) and a portion of a 1.0 Community Outreach Specialist to ensure that Detroit parents, caregivers, and health providers receive information about infant safe sleep. DHWP will continue to promote the safe sleep message through educational classes at WIC clinics, ad-hoc classes at hospitals and community-based organizations, pre-schools, high schools and universities, stores selling baby toys or furniture, unlicensed daycare centers, and through a media campaign. DHWP created a Safe Sleep PSA in FY2015 and will continue to promote the announcement on public television channels 10 and 22, radio spots, bus ads, billboards, and social media throughout the city. In addition, LMCH block grant dollars will support the creation of a Detroit

"Crib" Bank in fall 2015, partnering with Crossroads of Michigan and other community partners to host and distribute the Pack N Plays while providing in-depth safe sleep education. DHWP will purchase a small supply of Pack N Plays in FY16, create and distribute safe sleep education materials and work with Crossroads to establish a system for in-kind or financial donations to sustain the Crib Bank for future years. Donations will be restricted to safety-approved sleep environments (bassinets, Pack N Plays) or funds to purchase safety-approved environments for the Crib Bank, which will be accessed by families meeting income requirements. A .5 FTE Community Health Educator will provide intensive safe sleep training to Crossroads staff, interns and volunteers by October 2015 to ensure that every family accessing a Pack N Play also receives counseling about the "ABC' S of Safe Sleep" (Babies sleep safest Alone, on their Backs, in a Crib, and a Smoke-free environment) and signs a pledge that any caregiver to their baby will follow the safe sleep message. Finally, LMCH funds will support a local adaptation of the CDC's *1,000 Grandmothers Project* to reduce the number of sleep-related infant deaths and will pilot the project at an African American church in early 2016. Safe sleep efforts will continue to target expecting parents, but will increase a focus on fatherhood engagement as well as grandparent and non-traditional caregiver education.

SPM S3) Depression across the life course

DHWP will utilize LMCH funds to support the 961-BABY maternal child health hotline, FIMR maternal home interviews, and bereavement support to link women to community mental health services throughout Detroit. When DHWP receives referrals for bereavement from other agencies, the Community Outreach Specialist sends a personalized condolence letter from the health department providing a list of local grief support and community mental health resources and a DHWP phone number to call for additional services. In addition, each FIMR maternal home interview conducted screens for signs of depression and each client is provided with a customized packet of resources as well as follow up calls to ensure that families are receiving the grief support they need. In FY16 DHWP will also explore other opportunities to promote depression screenings during Well-Woman Visits, prenatal, and postpartum visits for women to ensure that mental health needs are met.

SPM S4) Provision of medical services and treatment for children with special health care needs

DHWP will use LMCH funds to As a co-lead on the Mayor's Task Force on the Wellbeing of Children (formerly Task Force on Child Abuse and Neglect), DHWP will use a small portion of LMCH funds to support advocacy, trainings, educational print materials and supplies for various Task Force initiatives aimed at preventing child abuse and neglect. This year the Task Force is focusing on several issues, including child sexual abuse prevention, safe sleep education, and issues impacting LGBT youth.

LOCAL MATERNAL CHILD HEALTH (MCH) GRANT PROGRAM COMMUNITY PLAN: FY 2016 (10/1/15 – 9/30/16) ATTACHMENT B
(Please attach to MI E-Grants – on a detailed budget line of your choice.)

1) If you are using these funds for a locally defined services category(ies), describe the a) service(s) or program(s), b) activity(ies), c) MCH population that will be served, and d) identify which national or state performance measure(s) that will be addressed, if any.

a. Maternal Health Program – Enabling Services Women – MCH

DHWP will use lessons learned from the Cincinnati First Steps Program's technical assistance provided in FY15 to continue to phase in elements of the program. The initiative uses the following approaches for improving local birth outcomes, including: 1) shared, consistent messaging around key MCH health issues, 2) real time surveillance of city birth outcomes and the establishment of a Detroit Baby data book to give providers and community leaders information on medical and social determinants of MCH in Detroit; and 3) enhanced referral to evidence-based home visiting services supported by Home Visiting Hub (HVH) agencies in addition to other supportive social services for new or expecting moms through the 961-BABY hotline. The program will collaborate with the Detroit-Wayne County Home Visiting Hub to assure collaborative network reporting of services and evidence-based quality care. Finally, *Detroit Baby* will include the development, buy-in, and distribution of key shared health messages to be standardized across the perinatal health system (hospitals, home visitors, social service agencies, public health service providers, etc.) aimed at reducing infant mortality and morbidity to ensure that all expecting families receive the same information in the same way with widespread linkage to appropriate services. In order to accomplish this goal, DHWP will continue to work with Coffective, a free mobile app already being utilized by Michigan WIC and local hospitals, to train DHWP staff and partners on key messages and referral systems, develop printed materials on key messages, tailor the Coffective website and app to be Detroit-specific in messaging and resources, and to promote key messages across every sector and agency that touches expecting families or families with infants. Staffing will include a 1.0 FTE Maternal Health Program Manager (MHM), and 1.7 FTE Epidemiologist. The program will also be supported by the Community Health Educator, Community Outreach Speicalist, and interns.

b. *Make Your Date. – Enabling Services Women – MCH*

LMCH funds will also support the City of Detroit's infant mortality reduction initiative *Make Your Date* (MYD) by providing citywide messaging, supporting preterm birth reduction classes, facilitating insurance enrollment on site, and accurate data collection and reporting. The MYD initiative is an evidence-based prenatal care project based on the science of measuring women for identification of short cervix as well as other risk factors for preterm birth, and providing a progesterone protocol to prevent preterm birth. MYD also provides enrolled women the advantage of group prenatal care, another evidence based component for improved birth outcomes. Detroit's main birthing hospital is the pilot site for the initiative and is working with the rest of the local health system to expand its initiative. Improvement in birth outcomes is the anticipated result of this initiative. Detroit PPOR data suggests that 50% of

c. *Fetal and Infant Mortality Review Program (FIMR) – Public Health Functions & Infrastructure –MCH/Enabling Services Women*

The The Maternal Health Program Manager will lead the city's Fetal Infant Mortality Review (FIMR) team and represent DHWP on the Child Death Review. L essons learned from FIMR/CDR will continue inform the work of the LMCH, and lead the creation of

recommendations for a community action team (Detroit Regional Infant Mortality Reduction Task Force) in response to identified needs. The Maternal Health Program Manager will coordinate FIMR, the Community Outreach Specialist will continue to conduct maternal home interviews, and a Nurse Contractor will continue to abstract cases. In addition to staffing, LMCH funds will supplement the FIMR allocation to support case abstractions, provide incentives for mothers to participate in maternal interviews, and travel to trainings, home interviews, and meetings.

d. Health Education – Enabling Services Women – MCH

A .5 FTE Community Health Educator, 1.0 Community Outreach Specialist and .2 Customer Service Rep (back up for the 961-BABY hotline) will support the Safe Sleep Program, Preconception/Interconception Care Enhancement Projects, and other maternal and child health education needs. The Community Health Educator will work with the Community Outreach Specialist to assess and respond to community needs, strengthen existing programs, and begin research/planning for programs including a fatherhood initiative aimed to engage fathers (as well as grandfathers, uncles, and male caretakers) in MCH health needs, as well as a tobacco cessation program used to increase linkage to the existing Michigan Quit-Line and assess the viability of local support groups or one on one counseling. The aim of the tobacco cessation program will be to assess barriers to smoking cessation and increase education about the effects of first-, second- and thirdhand smoke exposure on fetuses and infants, while also providing resources and incentives to quit for households with young children who have one or more smokers living in the home.

e. Bereavement Support – Enabling Services Women – MCH

There were 151 Detroit infant deaths in 2012. Bereavement counseling in collaboration with Tomorrow's Child and Detroit-based grief support groups will continue in order to provide referrals and support to families who have had an infant death. This work will be done in the most cost effective manner, maintaining quality and service efficiency –via service targeted referrals and screening by 961-BABY Advocate as led by the Maternal Health Manager.

f. Insurance Enrollment – Enabling Services Women/Children – MCH

The DHWP will support efficient and effective use of available insurance enrollment navigator programs and resources to assure enrollment of eligible women, infants and children into insurance opportunities made available by the Affordable Care Act (ACA). DHWP convened an ACA work group in 2014 to maximize new insurance enrollment opportunities. This work group, consisting of a diverse group of agencies in Detroit that are trained and willing to enroll eligible individuals in Healthy Michigan or the Insurance Market Place, will be utilized to assure that every available opportunity is taken for Detroit resident insurance enrollment. Block grant funds will be used to support Public Health Analyst to work in collaboration with the DHWP Community and Contract Manager to assure insurance enrollment services exist on a wide spread basis in the city and to participate with local partners in collaborative

enrollment efforts. Mileage expenses will also be covered with LMCH funds as needed.

g. *Fit Kids – Enabling Services Children - MCH*

DHWP will provide resources to the Wayne Children's Healthcare Access Program (WCHAP) in Detroit to support services for overweight and obese children to increase physical activity and improve nutrition using an evidence based model called Fit Kids 360. LMCH funds will be used to support Fit Kids services for 4 cohorts, or at least 50-100 children and families in Detroit. In addition to the children who enroll in Fit Kids, the program promotes fitness and nutrition for entire families by providing education and opportunities to engage in fitness with the enrolled child to siblings, parents, and other caregivers who attend the sessions.

h. Maternal Child Health (MCH) Quality Improvement. – Public Health Functions and Infrastructure – MCH

Funds will support a MCH Quality Management Consultant to work with DHWP leadership, management, program staff and the newly established Public Health Advisory Committee (PHAC) to identify priority MCH quality indicators for the city, link priority indicators to the City of Detroit Dashboard, and develop a continuous quality improvement plan. MCH quality improvement efforts will be linked to DHWP programs, Fetal Infant Mortality Review (FIMR), Healthcare Effectiveness Data and Information Set (HEDIS) measures, as well as partner initiatives and collaborations. Pre and interconception health, safe sleep, breastfeeding, and linkage to and coordination with existing programs for collective impact will be prioritized.

2) Using the table below, identify service categories that will be supported with this funding. Indicate how much funding will be used per service category by population. *Please be sure your financial budget allocations match the projections below. The LMCH plan and grant fund distribution in the budget must match.*

PROJECTED OUTCOMES AND FUNDS ALLOCATED - FY 2015/2016

LOCAL MATERNAL CHILD HEALTH (MCH) GRANT PROGRAM COMMUNITY PLAN: FY 2016 (10/1/15 – 9/30/16)
(Please attach to MI E-Grants – on a detailed budget line of your choice.)

Program Element	# Women (20 – 44)	Amount Allocated	# Children (0-9)	Amount Allocated	# Adolescents (10 – 19)	Amount Allocated	TOTAL Projected Outcomes	TOTAL Allocation
LMCH - Children Enabling								
Team Lead (Lead)			63	$33,000			63	$33,000
Community Health Adv.			63	$27,000			63	$27,000
Community Health Adv.			63	$45,000			63	$45,000
Community Health Adv.			63	$45,000			63	$45,000
RN (Lead)			50	$43,550			50	$43,550
Social Worker	50		100	$27,500	100	$27,500	250	$55,000
Fringe @ 42%								$104,391
Supplies and Materials								$6,023
Contractual: Fit Kids	50		25	$20,503	25	$20,503	100	$41,006
Contractual: MCDC			100	$20,000	100	$20,000	200	$40,000
Other: Lead Inspection			8	$3,800.00	7	$3,325.00	15	$7,125
Total Direct Costs								$447,095
Total Indirect Costs (SEMHA/DHWP)								*$70,194*
TOTAL COSTS								**$517,289**
City of Detroit Office of Assurance and Compliance (OAC)								*$15,900*
TOTAL COSTS	**100**		**535**		**232**		**867**	**$533,189**
LMCH - Children Direct								
Contractual: MCDC			50	$5,000	50	$5,000	100	$10,000
Total Direct Costs								$10,000
Total Indirect Costs (SEMHA/DHWP)								*$1,570*
TOTAL COSTS								**$11,570**
City of Detroit Office of Assurance and								*$512*

LOCAL MATERNAL CHILD HEALTH (MCH) GRANT PROGRAM COMMUNITY PLAN: FY 2016 (10/1/15 – 9/30/16)
(Please attach to MI E-Grants – on a detailed budget line of your choice.)

LMCH - Women Enabling								
Cust. Service Rep	96	$7,200			24	$800	120	$8,000
MCH Health Educator	1080	$20,250			120	$2,250	1200	$22,500
Comm. Outreach Spec.	800	$40,500			90	$4,500	890	$45,000
Fringe @ 42%								$31,710
Travel								$5,813
Supplies and Materials								$5,920
Contractual: Make Your Date	1000	$200,000					1000	$200,000
Contractual: HFHS Group Prenatal Care	50	$10,000					50	$10,000
Other: Outreach Events	200	$4,500			50	$500	250	$5,000
961 BABY/MCH Resource Guide	600	$1,500					600	$1,500
Safe Sleep Program	300	$18,000					300	$18,000
Well Woman Project	40	$3,000					40	$3,000
FIMR Maternal Interviews	20	$1,000					20	$1,000
Total Direct Costs								$357,443
Total Indirect Costs (SEMHA/DHWP)								*$56,119*
TOTAL COSTS								**$413,562**
City of Detroit Office of Assurance and Compliance (OAC)								*$12,823*
TOTAL COSTS	**4186**				**284**		**4470**	**$426,385**

LOCAL MATERNAL CHILD HEALTH (MCH) GRANT PROGRAM COMMUNITY PLAN: FY 2016 (10/1/15 – 9/30/16)
(Please attach to MI E-Grants – on a detailed budget line of your choice.)

ATTACHMENT B

LMCH Public Health Functions & Infrastructure								
Program Manager								$85,000
Maternal Health Mgr.								$70,000
Epidemiologist								$56,100
Epidemiologist								$51,000
Communications Manager								$29,400
Public Health Analyst								$16,380
Executive Coord/Contracts Spec.								$21,000
Business Officer								$22,680
Fringe Benefits								$147,655
Travel								$6,600
Supplies and Materials								$7,690
Contractual								$54,441
Other Expenses								$50,847
Total Direct Costs								$618,794
Total Indirect Costs (SEMHA/DHWP)								*$97,151*
TOTAL COSTS								***$715,945***
City of Detroit Office of Assurance and Compliance (OAC)								*$22,055*
TOTAL COSTS								**$738,000**
TOTALS							**5437**	**$1,709,656**

Local Health Department: Detroit Department of Health and Wellness Promotion

Michigan Title V MCH Block Grant
Selected NPMs, State Priorities & Planned SPMs

No.*	National Priority Area	National Performance Measure (NPM)	MCH Population Domain	State Priority Need
1	Well-woman visit	Percent of women with a past year preventive medical visit	Women/Maternal Health	Reduce barriers, improve access, and increase the availability of health services for all populations
3	Perinatal regionalization	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Perinatal/Infant Health	Support coordination and linkage across the perinatal to pediatric continuum of care
4	Breastfeeding	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months	Perinatal/Infant Health	Support coordination and linkage across the perinatal to pediatric continuum of care
6	Developmental screening	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	Child Health	Invest in prevention and early intervention strategies, such as screening
10	Adolescent well-visit	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	Adolescent Health	Reduce barriers, improve access, and increase the availability of health services for all populations
11	Medical home	Percent of children with and without special health care needs having a medical home	CSHCN	Increase family and provider support and education for Children with Special Health Care Needs
12	Transition	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care	CSHCN	Increase family and provider support and education for Children with Special Health Care Needs
13	Oral health	A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	Cross-cutting/Life course	Increase access to and utilization of evidence-based oral health practices and services
	State Priority Area	**State Performance Measure (SPM)** *To be finalized in 2016 per HRSA requirements*	**MCH Population Domain**	**State Priority Need**
S1	TBD	TBD – Lead Prevention	Child Health	Foster safer homes, schools, and environments with a focus on prevention
S2	TBD	TBD—Safe Sleep Environments	Perinatal/Infant Health	Foster safer homes, schools, and environments with a focus on prevention
S3	TBD	TBD—Depression across the Life Course	Cross-cutting/Life course	Promote social and emotional well-being through the provision of behavioral health services
S4	TBD	TBD—Provision of medical services and treatment for children with special health care needs	CSHCN	Reduce barriers, improve access, and increase the availability of health services for all populations

**Please note that the NPM numbers mirror the federal NPM designations and therefore the numbering is not sequential.*

Attachment 8B

REVISED - 6/28/16

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PROGRAM BUDGET - COST DETAIL

Attachment B.2

- Use WHOLE DOLLARS Only

Program	CODE	BUDGET PERIOD		Date Prepared
LMCH: Other-Children Enabling		From: 10/01/15	To: 09/30/16	10/1/2015
Local Agency: Detroit Department of Health and Wellness Promotion		ORIGINGAL BUDGET X	AMENDED BUDGET	AMENDMENT NUMBER

1. SALARIES & WAGES: POSITION DESCRIPTION	POSITIONS REQUIRED	TOTAL SALARY		
Team Lead - Marlene Rodriguez (Lead)	0.50	55,000		$ 27,500
Community Health Advocate - Inger Blair (Lead)	0.50	45,000		$ 22,500
Registered Nurse - C Brown (Lead)	0.57	65,000		$ 37,050
Community Health Advocate (Lead) - *Maribel Santana*	0.90	45,000		$ 21,330
Community Health Advocate (Lead) - *Tamika Estes*	0.90	45,000		$ 16,538
Community Relations- Michael McElrath	0.25	70,000		$ 17,500
Community Relations-TBD	0.25	70,000		$ 17,500
Social Worker (O Ramsey) Ped. Dental and MCH	1.00	55,000		$ 55,000
1. TOTAL SALARIES and WAGES:	3.8700	$ 350,000	$ -	**$ 214,918**

2. FRINGE BENEFITS: (Specify) — Composite Rate: **42.00%**

X FICA | X HOSPITAL INS | X VISION | X WORK COMP

X UNEMPLOYMENT INS | X LIFE INS | ☐ HEARING INS | ☐ OTHER:

X RETIREMENT | X DENTAL INS

2. TOTAL FRINGE BENEFITS: $ 90,265

3. TRAVEL: (Specify if any item exceeds 10% of Total Expenditures)

Mileage	5,000.00
3. TOTAL TRAVEL:	**$ 5,000**

4. SUPPLIES & MATERIALS: (Specify if any item exceeds 10% of Total Expenditures)

Routine office supplies and materials	$ 9,496
4. TOTAL SUPPLIES & MATERIALS:	**$ 9,496**

5. CONTRACTUAL: (Subcontracts)

Name	Address	Amount	
		$	-
Pediatric Dental	MCDC	$	50,000
		$	-
Fit Kids	Wayne County Childrens Healthcare Access Project	$	41,006
		5. TOTAL CONTRACTUAL:	**$ 91,006**

6. EQUIPMENT: (Specify)

	Amount
6. TOTAL EQUIPMENT:	

7. OTHER EXPENSES: (Specify if any item exceeds 10% of Total Expenditures)

				Amount	
CHW Training				$3,075.00	
Lead Inspections	$ 475.00	15		$7,125	
PLUG LINE ITEMS-Unused Funds					
M. Santana			19,170		
T. Estes			23,963		
Added Salary			-43,133		
Fringes Savings on Reduced Salary			18,116		-
Added Services			-18,116		
				$0.00	
(List all items and provide each cost, then enter total below)			**7. TOTAL OTHER EXPENSES:**		**$10,200**

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7)	**$ 420,885**

9. INDIRECT COST CALCULATIONS:

(City of Detroit) Rate #1	Base $ $ 502,025	x Rate	0.00%	=	$ -
(SEMHA) Rate #2	Base $ $ 420,885	x Rate	5.00%	=	$ 21,044
(DHD) Rate #3	Base $ $ 420,885	x Rate	0.00%	=	$ -
			9. TOTAL INDIRECT EXPENDITURES:		**$ 21,044**

10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9)	**$ 441,929**

AUTHORITY: P.A. 368 of 1978

COMPLETION: Is Voluntary, but is required as a condition of funding

The Department of Community Health is an equal opportunity employer, services and programs provider

REVISED - 6/10/16

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PROGRAM BUDGET - COST DETAIL

Attachment B.2

- Use WHOLE DOLLARS Only

Program		CODE	BUDGET PERIOD From:	To:	Date Prepared
LMCH: Women Enabling			10/01/15	09/30/16	10/1/2015
Local Agency			ORIGINGAL BUD X	AMENDED BUDGET	AMENDMENT NUMBER
Detroit Department of Health and Wellness Promotion					
1. SALARIES & WAGES: POSITION DESCRIPTION		POSITIONS REQUIRED	TOTAL SALARY		
Customer Svc Rep/Data Tech - P Hutchison		0.20	$40,000		$8,000
MCH Health Educator - B. Lawrence		0.50	$45,000		$22,500
Community Outreach Specialist - M Johnson		1.00	$45,000		$45,000
1. TOTAL SALARIES and WAGES:		1.7000	$ 130,000	$ -	$75,500
2. FRINGE BENEFITS: (Specify)				Composite Rate	
x FICA	x HOSPITAL INS	X VISION	x WORK COMP.	42.00%	
x UNEMPLOYMENT INS	x LIFE INS	□ HEARING II	□ OTHER:		
x RETIREMENT	x DENTAL INS		**2. TOTAL FRINGE BENEFITS:**		$31,710
3. TRAVEL: (Specify if any item exceeds 10% of Total Expenditures)					
Mileage, Conferences and Training				5,813	
				3. TOTAL TRAVEL:	$5,813
4. SUPPLIES & MATERIALS: (Specify if any item exceeds 10% of Total Expenditures)					
General office supplies				$ 5,920	
				4. TOTAL SUPPLIES & MATERIALS:	$5,920
5. CONTRACTUAL: (Subcontracts)					
Name	**Address**			**Amount**	
Make Your Date	Wayne State University School of Medicine			$ 200,000	
				$ -	
				$ -	
Group Prenatal/Education Classes	HFHS/WIN Network			$ 10,000	
				$ -	
				5. TOTAL CONTRACTUAL:	$210,000
6. EQUIPMENT: (Specify)				**Amount**	
				6. TOTAL EQUIPMENT:	$0
7. OTHER EXPENSES: (Specify if any item exceeds 10% of Total Expenditures)				**Amount**	
Outreach Events				$5,000	
Printing costs/supplies for Resource Guides				$1,500	
Crib Bank and Safe Sleep Training	Safe Sleep Program			$18,000	
Focus Groups	Well-Woman Project/PRAMS			$3,000	
FIMR Incentives for Maternal Interviews	FIMR			$1,000	
(List all items and provide each cost, then enter total below)				**7. TOTAL OTHER EXPENSES:**	$28,500
8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7)					$367,443
9. INDIRECT COST CALCULATIONS:					
(City of Detroit) Rate #1	Base $ $ 426,353	x Rate	0.00%	=	$0
(SEMHA) Rate #2	Base $ $ 357,443	x Rate	5.00%	=	$17,872
(DHD) Rate #3	Base $ $ 357,443	x Rate	0.00%	=	$0
				9. TOTAL INDIRECT EXPENDITURES:	$17,872
10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9)					$375,316

AUTHORITY: P.A. 368 of 1978
COMPLETION: Is Voluntary, but is required as a condition of funding.

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REVISED - 6/28/16

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PROGRAM BUDGET - COST DETAIL

Attachment B.2

- Use WHOLE DOLLARS Only

Program	CODE	BUDGET PERIOD From:	To:	Date Prepared
LMCH: Pulic Health Funcions & Infrastructure		10/01/15	09/30/16	3/21/2016
Local Agency	ORIGINGAL BUDGET		AMENDED BUDGET	AMENDMENT NUMBER
Detroit Department of Health and Wellness Promotion			X	

1. SALARIES & WAGES: POSITION DESCRIPTION	POSITIONS REQUIRED	TOTAL SALARY			
Program Manager - *Y. Hill-Ashford*	1.00	$67,358		$	67,358
Maternal Health Program Manager - *C. Harmell*	1.00	$ 4,038		$	4,038
Maternal Health Program Coordinator - *Sandra King*	1.00	$ 33,654		$	33,654
Epidemiologist - *C. Obianwu*	0.85	27,000		$	7,057
Epidemiologist - *C. Obianwu*	0.85	6,000		$	-
Epidemiologist - *Haifa Haroon*	0.85	33,000		$	29,423
Epidemiologist - *Alex Hill*	0.85	60,000		$	31,973
Public Health Analyst - *J. Floyd*	0.21	78,000		$	14,994
Communications Specialist - *T. Ashford*	0.42	70,000		$	30,022
Chief Business Officer - *B Cerda*	0.21	108,000		$	4,128
Exec Coordinator/Contract Specialist - *V Benjamin*	0.42	50,000		$	22,454
EPSDT Coordinator- Tracey King	1.00	45,000	0.250		11,250
Birthing Project Coordinator-TBD	1.00	50,000	0.250	$	12,500
Birthing Project Community Health Worker- Bianca Pritchett	1.00	45,000	0.250	$	11,250
Community Health Worker - *C. Cochran*	0.80	50,000	0.250	$	13,333
Fatherhood Advocate- Peter Williams	1.00	45,000	0.250	$	11,250
1. TOTAL SALARIES and WAGES:	12.4600	$ 772,050		$	304,684

2. FRINGE BENEFITS: (Specify)				Composite Rate	
X FICA	X HOSPITAL INS	X VISION	X WORK COMP	42.00%	
X UNEMPLOYMENT INS	X LIFE INS	☐ HEARING INS	☐ OTHER:		
X RETIREMENT	X DENTAL INS			2. TOTAL FRINGE BENEFITS:	$ 127,967

3. TRAVEL: (Specify if any item exceeds 10% of Total Expenditures)		
Mileage		
Travel to conferences and training		$ 1,100
Birthing Project Staff Mileage		$ 5,500
Healthy Start Conference-September 26-28 -2016		$ 833
CityMatCH Conference- September 12-17 2016		$ 3,600
		$ 3,600
	3. TOTAL TRAVEL:	$ 14,833

4. SUPPLIES & MATERIALS: (Specify if any item exceeds 10% of Total Expenditures)		
Routine office supplies and materials	$ 3,690	
Computer Supplies Birthing Project	$ 7,400	
Provider and client eduation and outreach materials	$ 2,000	
Birthing Project Detroit Training Materials and Supplies	$ 5,000	
	4. TOTAL SUPPLIES & MATERIALS:	$ 18,090

5. CONTRACTUAL: (Subcontracts) Name	Address	Amount	
Collective			
Media Purchases	Media Authority/TBD	$ 10,000	
Child Death Review/Scene Investigation	MPHI	$ 23,191	
Birthing Project USA Founder Training Consultant (K. Hall-Turjillo)Travel and Lodging		$ 10,000	
		$ 5,000	
		$ -	
FIMR Suppl Case Abstraction & Maternal I *M. Ruehle*		$ 10,000	
		5. TOTAL CONTRACTUAL:	$ 58,191

6. EQUIPMENT: (Specify)	Amount	
	6. TOTAL EQUIPMENT:	$ -

7. OTHER EXPENSES: (Specify if any item exceeds 10% of Total Expenditures) Others (explain):		Amount	
Event Coordinator			
Planning	Smoking Cessation/Fatherhood	$1,250	
Journal Articles and Subscriptions (Medline, PubMed)		$ 10,000	
Phones/Internet		$ 1,000	
Mayor's Task Force Wellbeing of Children	Advocacy/Prevention of Child Abuse & Neglect	$ 18,069	
Rent MBPI		$ 5,000	
Rent Family Place		$ 19,570	
Comcast		$ 4,070	
Birthing Project Detroit Kick-off		$ 138	
Evaluation (BP-USA National Evaluator T. Nulfo)		$ 3,000	
Birthing Project Sisterfriend Community Health Worker Training		$ 5,000	
BP Program Materials and Supplies (incl programs for mothers and fathers)		$ 11,031	
Detroit Birthing Project -Mini Grant / Site Events/SisterFriend stipends		$ 2,000	
Marketing Materials		$ 9,000	
(List all items and provide each cost, then enter total below)		$ 6,100	
		7. TOTAL OTHER EXPENSES:	$ 95,228

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7)					$ 618,794
9. INDIRECT COST CALCULATIONS:					
(City of Detroit) Rate #1 Base $ $	738,085	x Rate	0.00%	=	$ -
(SEMHA) Rate #2 Base $ $	618,794	x Rate	5.00%	=	$ 30,940
(DHD) Rate #3 Base $ $	618,794	x Rate	0.00%	=	$ -
			9. TOTAL INDIRECT EXPENDITURES:		$ 30,940
10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9)					$ 649,733

AUTHORITY: P.A. 368 of 1978

COMPLETION: Is voluntary, but is required as a condition of funding

DCH-0396(8) (Rev. 9-04) (EXCEL) Previous Editions Obsolete

The Department of Community Health is an equal opportunity employer, services and programs provided

Use Additional Sheets as Needed

Attachment 9

ATTACHMENT I

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

FY 15/16 Comprehensive Agreement

INSTRUCTIONS

FOR THE

ANNUAL BUDGET

INSTRUCTIONS FOR THE ANNUAL BUDGET FOR LOCAL HEALTH SERVICES

TABLE OF CONTENTS

INSTRUCTIONS FOR THE

ANNUAL BUDGET

FOR LOCAL HEALTH SERVICES

I. INTRODUCTION

The Annual Budget for Local Health Services is completed on a state fiscal year basis, and is used to establish budgets for many Department programs. In the Annual Budget, the Department consolidates many of its categorical programs' funding and Essential Local Public Health Services (ELPHS) (formerly known as the local public health operation's funding) into a single, Comprehensive Agreement for local health departments. The Department's Plan and Budget Framework serves as a principal reference point for budget development.

The Annual Budget for Local Health Services must be completed in accordance with and adhere to the established requirements as specified in these instructions and submitted to the Department as required by the agreement.

II. MINIMUM BUDGETING REQUIREMENTS

A. **Cost Principles** - Types or items of cost which will be considered for reimbursement are generally consistent with definitions contained in Title 2 Code of Federal Regulations CFR, Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

B. **Federal Block Grant Funds** - Maternal & Child Health and Preventive Health Block Grant funds may not be used to: provide inpatient services; make cash payments to intended recipients of health services; purchase or improve land; purchase, contract or permanently improve (other than minor remodeling defined as work required to change the interior arrangements or other physical characteristics of any existing facility or installed equipment when the cost of the remodeling incident does not exceed $2,000) any building or other facility; or purchase major medical equipment (any item of medical equipment having a unit cost of over $10,000 and used in the diagnosis or treatment of patients, excluding equipment typically used in a laboratory); satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of Federal funds; or provide financial assistance to any entity other than a public or nonprofit private entity.

C. **Expenditure and Funding Source Breakdown** - For purposes of development, analysis and negotiation activities must be budgeted at the individual expenditure and funding source category level on the Annual Budget for Local Health Services.

D. **Special Budget Requirements for Certain Categorical Program Elements** - The Annual Budget for Local Health Services is completed in the MI E-Grants System through the application budget to include details for all program elements (excluding Administration and Grantee Support).

E. **Local MCH -** Local MCH funds can be used for general Maternal Child Health (MCH) activity. These funds are to be budgeted as a funding source under any of the appropriate program element(s) listed or a locally defined program which is defined in the LMCH Community Plan. The Local MCH projects need to be budgeted separately instead of being distributed in projects:

1. Childrens Special Hlth Care Svc-MCH
2. Direct Services Children-MCH
3. Direct Services Women-MCH
4. Enabling Services Children -MCH
5. Enabling Services Women -MCH
6. Family Planning-Adolescents-MCH
7. Family Planning-Women-MCH
8. Immunization-Children-MCH
9. Immunization-Women-MCH
10. Maternal Infant Health Program (MIHP)-Children-MCH
11. Maternal Infant Health Program (MIHP)-Women-MCH
12. Public Health Functions & Infrastructure-MCH

If an agency wants to utilize this funding for another purpose, approval must be obtained from the Division of Family and Community Health. These funding sources cannot be used under the WIC element except in extreme circumstances where a waiver is requested in advance of expenditures, and evidence is provided that the expenditures satisfy all funding requirements. The MCH activities should address the priorities identified in the community health assessment and improvement process.

III. REIMBURSEMENT CHART

A. Program Element/Funding Source

The Program Element/Funding Source column provides a listing of all currently funded MDHHS programs that are included in the Comprehensive Agreement. When applicable, funding sources are specified.

B. Reimbursement Methods

The Reimbursement Methods column specifies the type of method used for each of the program element/funding sources. Funding under the Comprehensive Agreement can generally be grouped under four (4) different methods of reimbursement. These methods are defined as follows:

1. **Performance Reimbursement** - A reimbursement method by which local agencies are reimbursed based upon the understanding that a certain level of performance (measured by outputs) must be met in order to receive full reimbursement of costs (net of program income and other earmarked sources) up to the contracted amount of state funds prior to any utilization of local funds. Performance targets are negotiated starting from the last year's negotiated target and the most recent year's actual numbers except for programs in which caseload targets are directly tied to funding formulas/annual allocations. Other considerations in setting performance targets include changes in state allocations from past years, local fiscal and programmatic factors requiring adjustment of caseloads, etc. Once total performance targets are negotiated, a minimum state funded performance target percentage is applied (typically 90% unless otherwise specified). If local Grantee actual performance falls short of the expectation by a factor greater than the allowed minimum performance percentage, the state maximum allocation for cost reimbursement will be reduced equivalent to actual performance in relation to the minimum performance.

2. **Fixed Unit Rate Reimbursement** - A reimbursement method by which local health departments are reimbursed a specific amount for each output actually delivered and reported.

3. **ELPHS** - A reimbursement method by which local health departments are reimbursed a share of reasonable and allowable costs incurred for required Essential Local Public Health Services (ELPHS), as noted in the current Appropriations Act.

4. **Staffing Grant Reimbursement** - A reimbursement method by which local health departments are reimbursed based upon the understanding that State dollars will be paid up to total costs in relation to the State's share of the total costs and up to the total state allocation as agreed to in the approved budget. This reimbursement approach is not directly dependent upon whether a specified level of performance is met by the local health department. Department funding under this reimbursement method is allocable and a source before any local funding requirements unless a special local match condition exists.

C. **Performance Level If Applicable**

The Performance Level column specifies the minimum state funded performance target percentage for all program elements/funding sources utilizing the performance reimbursement method (see above). If the program elements/funding source utilizes a reimbursement method other than performance or if a target is not specified, N/A (not-available) appears in the space provided.

D. **Performance Target Output Measures**

Performance Target Output Measure column specifies the output indicator that is applicable for the program elements/ funding source utilizing the performance reimbursement method. Output measures are based upon counts of services delivered.

E. **Subrecipient or Contractor Designation**

The Subrecipient or Contractor Designation column identifies the type of relationship that exists between the Department and grantee on a program-by-program basis. Federal awards expended as a subrecipient are subject to audit or other requirements of OMB Circular A-133 and Title 2 Code of Federal Regulations (CFR). Payments made to or received as a Contractor are not considered Federal awards and are, therefore, not subject to such requirements.

1. Subrecipient

A subrecipient is a non-Federal entity that expends Federal awards received from a pass-through entity to carry out a Federal program, but does not include an individual that is a beneficiary of such a program; or is a recipient of other Federal awards directly from a Federal Awarding agency. Therefore, a pass-through entity must make case-by-case determinations whether each agreement it makes for the disbursement of Federal program funds casts the party receiving the funds in the role of a subrecipient or a contractor. Subrecipient characteristics include:

a. Determines who is eligible to receive what Federal assistance;

b. Has its performance measured in relation to whether the objectives of a Federal program were met;

c. Has responsibility for programmatic decision making;

d. Is responsibility for adherence to applicable Federal program requirements specified in the Federal award; and

e. In accordance with its agreements uses the Federal funds to carry out a program for a public purpose specified in authorizing status as opposed to providing goods or services for the benefit of the pass-through entity.

2. Contractor

A Contractor is for the purpose of obtaining goods and services for the non-Federal entity's own user and creates a procurement relationship with the Grantee. Contractor characteristics include:

a. Provides the goods and services within normal business operations;

b. Provides similar goods or services to many different purchasers;

c. Normally operates in a competitive environment;

d. Provides goods or services that are ancillary to the operation of the Federal program; and

e. Is not subject to compliance requirements of the Federal program as a result of the agreement, though similar requirements may apply for other reasons.

In determining whether an agreement between a pass-through entity and another non-Federal entity casts the latter as a subrecipient or a contractor, the substance of the relationship is more important than the form of the agreement. All of the characteristics listed above may not be present in all cases, and the pass-through entity must use judgment in classifying each agreement as a subaward or a procurement contract.

F. Type of Project

The type of project designation is indicated by footnote and is used if the project meets the Research and Development Project criteria. Research and Development Projects are defined by Title 2 CFR, Section 200.87, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards,

Research and development (R&D) means all research activities, both basic and applied, and all development activities that are performed by non-Federal entities. Research is defined as a systematic study directed toward fuller scientific knowledge or understanding of the subject studied. The term research also includes activities involving the training of individuals in research techniques where such activities utilize the same facilities as other research and development activities and where such activities are not included in the instruction function. Development is the systematic use of knowledge and understanding gained from research directed toward the production of useful materials, devices, systems, or methods, including design and development of prototypes and processes.

G. Reimbursement Chart

The following Reimbursement Chart notes elements/funding sources, applicable payment methods, target levels, output measures for each program/element having a performance reimbursement option. In addition, the chart also provides the subrecipient/ Contractor designations, as in prior years:

REIMBURSEMENT CHART				
Program Element/ Funding Source[1]	**Reimbursement Method[2]**	**Performance Level If Applicable[3]**	**Performance Target Output Measure**	**Subrecipient or Contractor Designation**
Adolescent STD Screening	Staffing[6]	N/A		Subrecipient
Body Art	Fixed Unit[2]	N/A		Contractor
Breast & Cervical Cancer Control Coordination	Performance[8]	97%	# Women Screened for Breast & Cervical Cancer	Subrecipient
Building Healthy Communities – Getting to the Heart of the Matter	Staffing[6]	N/A		Subrecipient
Centralized Access Home Visiting Hub	Staffing[6]	N/A		Subrecipient
Childhood Lead Poisoning Education & Outreach	Staffing[6]	N/A		Subrecipient
Childhood Lead Poisoning Intervention	Staffing[6]	N/A		Subrecipient
Childhood Lead Poisoning Prevention	Staffing[6]	N/A		Subrecipient
Childhood Lead Poisoning Prevention (CLPP) Elevated Lead Case Management	Staffing[6]	N/A		Subrecipient
CSHCS – Case Management/Care Coordination	Fixed Unit Rate[7]	N/A		Contractor
CSHCS Medicaid Outreach	Staffing[6]	NA		Subrecipient
CSHCS - Outreach & Advocacy	Staffing[6]	N/A		Subrecipient
Communities Uniting for Suicide Prevention	Staffing[6]	N/A		Subrecipient

REIMBURSEMENT CHART				
Program Element/ Funding Source[1]	**Reimbursement Method[2]**	**Performance Level If Applicable[3]**	**Performance Target Output Measure**	**Subrecipient or Contractor Designation**
Comprehensive Cancer Control (CCC) Community Implementation Project	Staffing[6]	N/A		Subrecipient
County Health Rankings & Roadmaps	Staffing[6]	N/A		Subrecipient
Eat Safe Fish	Staffing[6]	N/A		Subrecipient
ELPHS				
MDHHS	Staffing[6]	N/A		Contractor
MDA	Performance	75%	% of Food Service Licensees received required inspections	Contractor
MDA-Food and Water Lead Safety Inspections	Staffing[6]	N/A		Contractor
MDEQ	Staffing[6]	N/A		Subrecipient
Hearing Program	Staffing[6]	N/A		Subrecipient
Vision Program	Staffing[6]	N/A		Subrecipient
Family Planning Services	Performance[5] [8] [13]	95%	# Unduplicated Clinic Users Served	Subrecipient
General Services	Staffing[6]	N/A		Subrecipient
Fetal Alcohol Spectrum Disorder Projects	Staffing[6]	N/A		Contractor
Fetal Infant Mortality Review (FIMR) Case Abstractions	Staffing[6]	N/A		Subrecipient
Gonococcal Isolate Surveillance Project	Staffing[6]	N/A		Subrecipient
Great Start Trauma Informed System Community Demonstration Grants				

REIMBURSEMENT CHART				
Program Element/ Funding Source[1]	**Reimbursement Method[2]**	**Performance Level If Applicable[3]**	**Performance Target Output Measure**	**Subrecipient or Contractor Designation**
Health Disparities Reduction and Minority Health	Performance Reimbursement	100%	Community Forum/Community Conversation Event held -Minimum Sessions held =1 -Minimum participants=20	Subrecipient
Highly Targeted Community Based HIV Prevention Services	Staffing[6]	N/A		Subrecipient
HIV/AIDS Linkage to Care	Staffing[6]	N/A		Subrecipient
HIV Prevention Services Categorical Non-Categorical	Staffing[6] Fixed Unit Rate [7][12]	N/A N/A		Subrecipient Contractor
HIV Ryan White Part B	Staffing[6]	N/A		Subrecipient
HIV/STD Partner Services	Staffing[6]	N/A		Subrecipient
HIV Surveillance Support	Staffing[6]	N/A		Subrecipient
HOPWA	Staffing[6]	N/A		Subrecipient
Immunization				
AFIX Follow-up Site Visit	Fixed Unit Rate[7]	N/A		Contractor
Immunization Billing Practice Infrastructure Enhancement	Staffing[6]	N/A		Subrecipient
Field Service Reps	Staffing[6]	N/A		Subrecipient
Immunization Action Plan	Staffing[6]	N/A		Subrecipient
Michigan Care Improvement Registry	Staffing[6]	N/A		Subrecipient
Nurse Education	Fixed Unit Rate[2][7]	N/A		Contractor
Vaccine Quality Assurance	Staffing[6]	N/A		Contractor

REIMBURSEMENT CHART				
Program Element/ Funding Source[1]	**Reimbursement Method[2]**	**Performance Level If Applicable[3]**	**Performance Target Output Measure**	**Subrecipient or Contractor Designation**
Program VFC/AFIX Site Visit	Fixed Unit Rate[2][7]	N/A		Contractor
Infant Safe Sleep	Staffing[6]	N/A		Subrecipient
Informed Consent	Fixed Unit Rate[2][7]	N/A		Contractor
Laboratory Services	Staffing[6]	N/A		Subrecipient
Lactation Consultant	Staffing[6]	N/A		Contractor
Local Agency Vendor Compliance Pilot	Staffing[6]	N/A		Subrecipient
Local Health Department (LHD) Sharing Support	Staffing[6]	N/A		Subrecipient
Local Maternal Child Health (MCH) Block Grant	Staffing[6]	N/A		Subrecipient
Local Tobacco Reduction	Staffing[6]	N/A		Subrecipient
Maternal Infant Early Childhood Home Visiting Initiative (MIECHV) Local Home Visiting Leadership Group	Staffing[6]	N/A		Subrecipient
Maternal Infant Early Childhood Home Visiting Program (MIECHVP) Healthy Families America Expansion	Staffing[6]	N/A		Subrecipient

REIMBURSEMENT CHART				
Program Element/ Funding Source[1]	**Reimbursement Method[2]**	**Performance Level If Applicable[3]**	**Performance Target Output Measure**	**Subrecipient or Contractor Designation**
Medicaid Outreach	Staffing[6]	N/A		Subrecipient
Michigan Abstinence Program	Performance[8][18]	90%	Number of unduplicated youth to be served	Subrecipient
Michigan Adolescent Pregnancy & Parenting Program	Staffing[6]	N/A		Subrecipient
Michigan Colorectal Cancer Screening Program	Performance[8]	90%	Number of women and men that complete a screening test.	Subrecipient
Michigan Health and Wellness 4 X 4 Plan - Implementation	Staffing[6]	N/A		Subrecipient
Michigan Home Visiting Initiative Rural Expansion Grant	Staffing[6]	N/A		Subrecipient
Million Hearts Michigan Learning Collaborative	Staffing[6]	N/A		Subrecipient
Nurse Family Partnership Services (NFP)	Staffing[6]	N/A		Subrecipient
Nurse Family Partnership (NFP) Medicaid Outreach	Staffing[6]	N/A		Subrecipient
Nutrition and Physical Activity Self-Assessment for Child Care	Staffing[6]	N/A		Subrecipient
Obesity Prevention Active Living Grant	Staffing[6]	N/A		Subrecipient
Public Health Emergency Preparedness (PHEP) Public Health Emergency Preparedness (PHEP) 10/1/2015-6/30/2016 **&** 7/1/2016-9/30/2016	Staffing[6] (14) (18)	N/A		Subrecipient

REIMBURSEMENT CHART				
Program Element/ Funding Source[1]	**Reimbursement Method[2]**	**Performance Level If Applicable[3]**	**Performance Target Output Measure**	**Subrecipient or Contractor Designation**
Public Health Emergency Preparedness (PHEP) Cities of Readiness Initiative (CRI) 10/1/2015-6/30/2016 & 7/1/2016-9/30/2016	Staffing[6] (14) (18)	N/A		Subrecipient
Public Health Emergency Preparedness (PHEP) Ebola Virus Disease (EVD) Phase II	Staffing[6]	N/A		Subrecipient
Regional Perinatal Care System	Staffing[6]	N/A		Contractor
Sexual Violence Prevention	Staffing[6]	N/A		Subrecipient
Sexually Transmitted Disease (STD) Control	Staffing[6]	N/A		Subrecipient
Sudden Unexplained Infant Death (SUID) And Other Infant Death	Fixed Unit Rate (2)(11)	N/A		Contractor
SEAL! Michigan Dental Sealant Program	Staffing[6]	N/A		Subrecipient
Taking Pride in Prevention	Performance[8](18)	90%	Number of unduplicated youth who complete at least 75% of program intervention	Subrecipient
Tobacco Dependence Treatment	Staffing[6]	N/A		Subrecipient
Tobacco Use Reduction in People with HIV/AIDS	Staffing[6]	N/A		Subrecipient
TB Control Directly Observed Therapy (DOT)	Staffing[6]	N/A		~~Contractor~~ Subrecipient
West Niles Virus Community Surveillance	Staffing[6]	N/A		Subrecipient

REIMBURSEMENT CHART				
Program Element/ Funding Source[1]	**Reimbursement Method[2]**	**Performance Level If Applicable[3]**	**Performance Target Output Measure**	**Subrecipient or Contractor Designation**
Worksite Wellness - Getting to the Heart of the Matter	Staffing[6]	N/A		Subrecipient
WIC - Resident	Performance[8]	97%	#Average Monthly Participation	Subrecipient
WIC - Breastfeeding	Staffing[6]	N/A		Subrecipient
WIC – Migrant	Staffing[6]	N/A		Subrecipient
WISEWOMAN Project Coordination	Performance[8] [9]	95%	# Clients Screened for Cardiovascular Disease Risk Factors	Subrecipient
Wurtsmith Water Recover	Staffing[6]	N/A		Contractor

Footnotes:

(1) Program element or funding source as applicable.
(2) Refer to the master Comprehensive agreement and the program and budget instructions package for further explanation of applicability of these reimbursement methods.
(3) Allocation to be reflected in individual programs during budgeting process.
(4) Not Applicable.
(5) Subject to statewide maintenance of effort requirement for Title X.
(6) State funding is first source (after fees and other earmarked sources).
(7) Fixed unit rate subject to actual costs.
(8) The performance reimbursement target will be the base target caseload established by MDHHS.
(9) Subject to a match requirement (hard or in-kind) of $1 for each $3 of MDHHS agreement funding for coordination.
(10) Fixed rate limited to contract amount.
(11) Up to 6 visits per family.
(12) Non-categorically funded Health Departments will be reimbursed at $11.00 per HIV test conducted up to a maximum of $2,000 annually.
(13) Each delegate agency must serve a minimum percentage of Title X users to access their total allocated funds. Quarterly FPAR data will be used to determine total Title X users and Plan First! enrollees.
(14) Public Health Emergency Preparedness funding must be expended by June 30, 2015 and is subject to a 10% match requirement as specified in the Public Health Emergency Preparedness (PHEP) Cooperative Agreement Guidance. LHDs must submit a nine-month budget and a quarterly Financial Status Report (FSR) column for this program element.
(15) Public Health Emergency Preparedness funding for July 1, 2015- September 30, 2015 is subject to a 10% match requirement as specified in the Public Health Emergency Preparedness (PHEP) Cooperative Agreement Guidance. LHD's must submit a three-month budget and a quarterly Financial Status Report (FSR) column for this program element.
(16) Project meets the Research and Development Criteria as defined by Title 2 CFR Section 200.87.
(17) Not Applicable.
(18) Subject to match requirement as specified in Attachment III -- Program Assurances and Specific Requirements.

IV. LOCAL ACCOUNTING SYSTEM STRUCTURE OF ACCOUNTS/COST ALLOCATION PROCEDURES

As in past years, no additional accounting system detail is being required beyond local uniform accounting procedures prescribed by the Michigan Department of Treasury, Local Financial Management System requirements, documentation requirements of categorical program funding sources and any local requirements. Some agencies may already have separate cost centers in their accounting system to directly identify costs and related funding of required services, but such breakdowns are not essential to being able to meet minimum reporting requirements if proper allocation procedures are used and adequate documentation is maintained. All allocations must have clearly measurable bases that directly apply to the amounts being allocated, must be documented with work papers that will provide an adequate audit trail and must result in a representative reporting of costs and funding for affected programs. More specific guidance can be found in Title 2 CFR, Part 200 Appendix V State/Local Government and Indian Tribe-Wide Central Service Cost Allocation Plans and the brochure published by the Department of Health and Human Services entitled "A Guide for State, Local and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government.

V. FORM PREPARATION - GENERAL

The MI E-Grants System on-line application, including the budget entry forms, are utilized to develop a budget summary for each program element administered by the local Grantee. The system is designed to accommodate any number of local program elements including those unique to a particular local Grantee. Applications, including budget forms, are completed for all program elements, regardless of the reimbursement mechanism, including Agency administration(s) fee for service program elements, categorical program elements, performance based program elements and Medicaid Outreach associated program elements. Budget entry is required for each major expenditure and source of fund categories for which costs/funds are identified.

VI. FORM PREPARATION - EXPENDITURE CATEGORIES

Budgeted expenditures are to be entered for each program element, project or group of services by applicable major category.

A. **Salaries and Wages**- This category includes the compensation budgeted for all permanent and part-time employees on the payroll of the Grantee and assigned directly to the program. This does not include contractual services, professional fees or personnel hired on a private contract basis. Consulting services, vendor services, professional fees or personnel hired on a private contracting basis should be included in "Other Expenses." Contracts with secondary recipient organizations such as cooperating service delivery institutions or delegate agencies should be included in Contractual (Sub-contract) Expenses.

B. **Fringe Benefits** - This category is to include, for at least the specified elements, all Grantee costs for social security, retirement, insurance and other similar benefits for all permanent and part-time employees assigned to the specified elements.

C. **Cap Exp for Equip & Fac** - This category includes expenditures for budgeted stationary and movable equipment used in carrying out the objectives of each program element, project or service group. The cost of a single unit or piece of equipment includes necessary accessories, installation costs, freight and other applicable expenses associated with the purchase of the equipment. Only budgeted equipment items costing $5,000 or more may be reported under this category. Small equipment items costing less than $5,000 are properly classified as Supplies and Materials or Other Expenses. This

category also includes capital outlay for purchase or renovation of facilities.

D. **Contractual (Subcontracts/Subrecipient)** - Use for expenditures applicable to written contracts or agreements with secondary recipient organizations such as cooperating service delivery institutions or delegate agencies. Payments to individuals for consulting or contractual services, or for vendor services are to be included under Other Expenses. Specify subcontractor(s) address, amount by subcontractor and total of all subcontractors.

E. **Supplies and Materials** - Use for all consumable items and materials including equipment-type items costing less than $5,000 each. This includes office, printing, janitorial, postage and educational supplies; medical supplies; contraceptives and vaccines; tape and gauze; prescriptions and other appropriate drugs and chemicals. Federal Provided Vaccine Value should be reported and identified on in Other Cost Distributions category. Do not combine with supplies.

F. **Travel** - Travel costs of permanent and part-time employees assigned to each program element. This includes costs of mileage, per diem, lodging, meals, registration fees and other approved travel costs incurred by the employee. Travel of private, non-employee consultants should be reported under Other Expenses.

G. **Communication Costs** - These are costs for telephone, Internet, telegraph, data lines, websites, fax, email, etc., when related directly to the operation of the program element.

H. **County/City Central Services** - These are costs associated with central support activities of the local governing unit allocated to the local health department in accordance with Title 2 CFR, part 200.

I. **Space Costs** - These are costs of building space necessary for the operation of the program.

J. **All Others (Line 11)** - These are costs for all other items purchased exclusively for the operation of the program element and not appropriately included in any of the other categories including items such as repairs, janitorial services, consultant services, vendor services, equipment rental, insurance, Automated Data Processing (ADP) systems, etc.

K. **Total Direct Expenditures** – The MI E-Grants System sums the direct expenditures budgeted for each program element, project or service grouping and records in the Total Direct Expenditure line of the Budget Summary.

L. **Indirect Cost** – These cost categories are used to distribute costs of general administrative operations that have not been directly charged to individual subrecipient programs. The Indirect Cost expenditures distribute administrative overhead costs to each program element, project or service grouping. Two separate local rates may apply to the agreement period (i.e., one for each local fiscal year). Use Calendar Rate 1 to reflect the rate applicable to the first part of the agreement period and Calendar Rate 2 for the rate applicable to the latter part. Indirect costs are not allowed on programs elements designated as vendor relationship

An indirect rate proposal and related supporting documentation must be retained for audit in accordance with records retention requirements. In addition, these documents are reviewed as part of the Single Audit, subrecipient monitoring visit, or other State of Michigan reviews.

Following is further clarification regarding indirect rate and/or cost allocation approval requirements to distribute administrative overhead costs, in accordance with Title 2 CFR Part 200 (formerly Circular A-87 2 CFR Part 225, Appendix E), for Local Health Departments budgeting indirect costs:

1. Local Health Departments receiving more than $35 million in direct Federal awards are required to have an approved indirect cost rate from a Federal Cognizant Agency. If your Local Health Department has received an approved indirect rate from a Federal Cognizant agency, attach the Federal approval letter to your MI E-Grants Grantee Profile.

2. Local Health Departments receiving $35 million or less in direct Federal awards are required to prepare indirect cost rate proposals in accordance with Title 2 CFR and maintain the documentation on file subject to review.
3. Local Health Departments that received approved indirect cost rates from another State of Michigan Department should attach their State approval letter to their MI E-Grants Grantee Profile.
4. Local Health Departments with cost allocation plans should reflect these allocations in the Other Cost Distributions budget category. See Section M. Other Cost Distribution for budgeting guidance.
5. As a Subrecipient of federal funds from MDHHS, a Local Health Department that has never received a negotiated indirect cost rate, your Local Health Department may elect to charge a de minimis rate of 10% of modified total direct costs (MTDC) based on Title 2 CFR part 200 requirements.

   MTDC includes all direct salaries and wages, fringe benefits, supplies and materials, travel, services, and contractual expenses up to the first $25,000 of each contract. MTDC excludes all equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs, and portions subcontractual/subaward expenses in excess of $25,000 per contract.

   Attach a current copy of the letter stating the applicable indirect costs rate or calculation information justifying the de minimis rate calculation to you MI E-Grants Grantee profile. **Detail on how the indirect costs was calculated must be shown on the Budget Detail Schedule**.

The amount of Indirect Cost should be allocated to all appropriate program elements with the total equivalent amount reflected as a credit or minus in the Administration projects.

M. Other Cost Distributions – Use to distribute various contributing activity costs to appropriate program areas based upon activity counts, time study supporting data or other reasonable and equitable means. An example of Other Cost Distributions is nursing supervision. The distribution process permits costs reflected in a single program element to be subsequently distributed, perhaps only in part, to other programs or projects as appropriate. If an allocation is made, the charges must be reflected in the appropriate program element and the offsetting credit reflected in the program element being distributed. **There must be a documented, well-defined rationale and audit trail for any cost distribution or allocation based upon Title 2 CFR, Part 200 Cost Principles** Local Health Departments using the cost distribution or cost allocation must develop the plan in accordance with the requirements described in Title 2 CFR, Part 200. Local Health Departments should maintain supporting documentation for audit in accordance with record retention requirements. The plan should include a Certification of Cost Allocation plan in accordance with Title 2 CFR, Part 200 Appendix V. The cost allocation plan documentation is not required to be submitted unless specifically requested.

Cost associated with the Essential Local Public Health Services (ELPHS), Maternal and Child Health (MCH) Block Grant and Fixed Fee may be budgeted in the associated program element and distributed to the associated projects.

Federal Provided Vaccine Value should be reported on a separate line and clearly identified.

N. Total Direct & Admin. Expenditures – The MI E-Grants System sums the indirect expenditures program element and records in the Total Indirect Expenditure line of the Budget Summary.

O. **Total Expenditures** – The MI E-Grants System sums the direct and indirect expenditures and records in the Total Expenditure line of the Budget Summary.

VII. FORM PREPARATION - SOURCE OF FUNDS

Source of Funds are to be entered for each program element, project or group of services by applicable major category as follows:

A. **Fees & Collections - Fees 1st & 2nd Party**–

i. 1st party funds projected to be received from private payers, including patients, source users and any member of the general population receiving services.

ii. 2nd party funds received from organizations, private or public, who might reimburse services for a group or under a special plan.

iii. Any Other Collections

B. **Fees & Collections - 3rd Party** – 3rd Party Fees - Funds projected to be received from private insurance, Medicaid, Medicare or other applicable titles of the Social Security Act directly related to the cost of providing patient care or other services (e.g., includes Early Periodic Screening, Detection and Treatment [EPSDT] Screening, Family Planning.)

C. **Federal/State Funding (Non-MDHHS)** - Funds received directly from the federal government and from any state Contractor other than MDHHS, such as the Department of Natural Resources and Environment (MDNRE). This line should also be used to exclude state aid funds such as those provided through the Michigan Department of Treasury under P.A. 264 of 1987 (cigarette tax).

D. **Federal Cost Based Reimbursement** – Funds received for Federal Cost Based Reimbursement which should be budgeted in the program in which they were earned.

E. **Federally Provided Vaccines** – The projected value of federally provided vaccine.

F. **Federal Medicaid Outreach** – (**Please note:** to be used only for Medicaid Outreach, CSHCS Medicaid Outreach or Nurse Family Partnership Medicaid Outreach program elements.) Funds projected to be received from the federal government for allowable Medicaid Outreach activities. This amount represents the anticipated 50% federal administrative match of local contributions.

G. **Required Match - Local** – Funds projected to be local contribution for programs that have a match contribution requirement (**Please note:** for Medicaid Outreach, CSHCS Medicaid Outreach, or Nurse Family Partnership Medicaid Outreach, this amount represents the 50% matching local contribution for allocable Medicaid Outreach Activities. Federal Medicaid Outreach and Required Local match amounts should equal each other.)

H. **Local Non-ELPHS** - Local funds budgeted for the following expenditures:

1. Expenditures for services not designated as required and allowable for ELPHS funding (e.g., medical examiner and inpatient maternity services); expenditures determined not to be reasonable; and, expenditures in excess of the maximum state share of funds available.

2. Any losses arising from uncollectible accounts and other related claims. Under-recovery of reimbursable expenditures from, or failure to bill, available funding sources that would otherwise result in exclusions from ELPHS funding, if recovered.

   However, no exclusion is required where the local jurisdiction has made and documented a decision to have local funds underwrite:

   a. The cost of uncollectible accounts or bad debts incurred in support of providing required or

allowable health services. An example of this condition would be for services provided to indigents who are billed as a matter of procedure with little chance for receipt of payment.

b. Potential recoveries or under-recoveries from other sources for the principal purpose of providing required and allowable health services at free or reduced cost to the public served by the Grantee. An example would be keeping fees for services at a reduced level for the benefit of the people served by the Grantee while recognizing that to do so limits recovery from third parties for the same types of services.

3. Contributions to a contingency reserve or any similar provisions for unforeseen events.
4. Charitable contributions and donations.
5. Salaries and other incidental expenditures of the chief executive of a political subdivision (i.e., county executive and mayor).
6. Legislative expenditures; such as, salaries and other incidental expenditures of local governing bodies (i.e., county commissioners and city councils). Do not enter board of health expenses.
7. Expenditures for amusements, social activities and other incidental expenditures related thereto; such as, meals, beverages, lodging, rentals, transportation and gratuities.
8. Fines, penalties and interest on borrowings.
9. Capital Expenditures - Local capital outlay for purchase of facilities and equipment (assets) are excluded from ELPHS funding.

I. **Other Non- ELPHS -** Funds budgeted from sources other than state, federal and local appropriations to the extent that they are not eligible for ELPHS (e.g., funding from local substance abuse coordinating grantee, local area on aging grantees).

J. **MDHHS - NON-COMPREHENSIVE -** Funds budgeted for services provided under separate MDHHS agreements. Examples include: funding provided directly by the Community Services for Substance Abuse for community grants, etc.

K. **MDHHS - COMPREHENSIVE -** This section includes all funding projected to be due under the Comprehensive Agreement from categorical programs and needs to equal the allocation.

L. **ELPHS - MDHHS Hearing** – This section includes all funding projected to be due under Comprehensive Agreement specific to the ELPHS MDHHS Hearing program and has to equal the MDHHS ELPHS Hearing allocation. Additional ELPHS to be budgeted for the Hearing Program must be entered into ELPHS – MDHHS Other. Hearing allocations may only be spent on the Hearing Program.

M. **ELPHS - MDHHS Vision** – This section includes all funding projected to be due under Comprehensive Agreement specific to the ELPHS MDHHS Vision program and has to equal the ELPHS MDHHS Vision allocation. Additional ELPHS to be budgeted for the Vision Program must be entered into ELPHS – MDHHS Other. Vision allocations may only be spent on the Vision Program.

N. **ELPHS – MDHHS Other** – This section includes all funding projected to be due under Comprehensive Agreement specific to the ELPHS MDHHS Other program for eligible program elements. Please note: The MI E-Grants System validates the ELPHS MDHHS Other budgeted funds across the applicable program elements to assure the agreement does exceed the ELPHS – MDHHS Other allocation.

O. **ELPHS – Food -** This section includes all funding projected to be due under Comprehensive Agreement specific to the ELPHS Food program and has to equal the ELPHS Food allocation.

P. **ELPHS – Drinking Water -** This section includes all funding projected to be due under Comprehensive

Agreement specific to the ELPHS Drinking Water program and has to equal the ELPHS Drinking Water allocation.

Q. **ELPHS – On-site Sewage** - This section includes all funding projected to be due under Comprehensive Agreement specific to the ELPHS On-site Sewage program and has to equal the ELPHS On-site Sewage allocation.

R. **MCH Funding** - This section includes all funding projected to be due under Comprehensive Agreement specific to the MCH eligible program elements. Please note: The MI E-Grants System validates the MCH budgeted funds across applicable program elements to assure the agreement does exceed the MCH allocation.

S. **Local Funds - Other** - Enter all local support in the appropriate element, project or service group column. This may include local property tax, and other local revenues (does not include fees).

T. **Inkind Match** – Enter Local Support from donated time or services.

U. **MDHHS Fixed Unit Rate** – Select the type of fee-for-services from the lookup to correspond with the program element.

VIII. SPECIAL BUDGET INSTRUCTIONS

Certain elements are supported by federal or other categorical program funds for which special budgeting requirements are placed upon grantees and subgrantees. These include:

Element	Federal or Other Funding Contractor
Public Health Emergency Preparedness	U.S. Department of Health & Human Services, Centers for Disease Control
WIC	U.S. Department of Agriculture, Food & Nutrition Service
Family Planning	U.S. Department of Health & Human Services, Public Health Service
Breast and Cervical Cancer	U.S. Department of Health & Human Services, Centers for Disease Control
CSHCS Outreach & Advocacy	Michigan Department of Health & Human Services
Medicaid Outreach Activities	Centers for Medicare and Medicaid Services

In general, subgrantee budgets must provide sufficient budget detail to support grantee budget requests and be in a format consistent with grantor Contractor requirements. Certain types of costs must receive approval of the federal grantor Contractor and/or the grantee prior to being incurred.

A. Public Health Emergency Preparedness (PHEP) Special Budget Requirements

Local Health Departments will receive the initial FY 15/16 allocation of the CDC Public Health Emergency Preparedness (PHEP) funds in nine equal prepayments for the period October 1, 2015 through June 30, 2016. LHDs must submit a nine-month budget and a quarterly Financial Status Report (FSR) for each of the following COMPREHENSIVE program elements:

1. Public Health Emergency Preparedness (PHEP) (October 1, 2015 – June 30, 2016)
2. Public Health Emergency Preparedness (PHEP)– Cities of Readiness (October 1, 2015 –June 30, 2016)
3. Laboratory Services - Bioterrorism (October 1, 2015 – September 30, 2016)

B. WIC Special Budget Requirements

1. **Cost/Funding Categories** - The following local budget breakdowns are required to fulfill WIC grant application budget requirements each fiscal year:

   Salaries & Fringe Benefits
   Automated Management Systems
   Space Utilization Costs
   Equipment
   Supplies
   Communications & Travel
   All Other Direct Costs
   Indirect Costs
   All Funding Sources by Type

   The WIC cost/funding categories and supporting budget detail requirements are satisfied by completion of an application budget form in the MI E-Grants System. General instructions for

these forms are contained at the end of this section.

Agencies receiving WIC-USDA Infrastructure grants must budget these funds as a separate element. Agencies must track and report expenditures separately on the FSR.

Agencies receiving WIC-USDA Breastfeeding Peer Counselor funds must budget these funds as a separate element. Agencies must track and report expenditures separately on the FSR. And comply with special reporting requirements.

2. **Costs Allowable Only With Prior Approval** - The following costs are allowable only with prior review/approval of the Michigan Department of Health & Human Services as specified by the U.S. Department of Agriculture, Food and Nutrition Service (Ref.: 7 CFR Part 246, and USDA-WIC Administrative Cost Handbook 3/86). Prior approval is accomplished by providing appropriate detail in the budget request approved by MDHHS or subsequently in a written request approved in writing by MDHHS.

   A. Automated Information Systems - which are required by a local Grantees except for those used in general management and payroll, including acquisition of automated data processing hardware or software whether by outright purchase or rental-purchase agreement or other method of acquisition.

   B. Capital Expenditures of $2,500 or More - such as the cost of facilities, equipment, including medical equipment, other capital assets and any repairs that materially increase the value or useful life of capital assets.

   C. Management Studies - performed by agencies or departments other than the local Grantee or those performed by outside consultants under contract with the local Grantee.

   D. Accounting and Auditing Services - performed by private sector firms under professional service contracts for purposes of preparation or audit of program and financial records/reports.

   E. Other Professional Services - rendered by individuals or organizations, not a part of the local Grantee, such as:

      1. Contractual private physician providing certification data.
      2. Contractual organization providing laboratory data.
      3. Contractual translators and interpreters at the local Grantee level.

   F. Training and Education - provided for employee development, which directly or indirectly benefits the grant program, to the extent that such training is contracted for or involves out-of-service training over extended periods of time.

   G. Building Space and Related Facilities - the cost to buy, lease or rent space in privately or publicly owned buildings for the benefit of the program.

   H. Non-Fringe Insurance and Indemnification Costs

   All charges to WIC must be necessary, reasonable, allowable and allocable for the proper and efficient administration of the program. Further information and cost standards are provided in federal instructions including Title 2 CFR, Part 200 and 7 CFR Part 3015.

C. Family Planning Special Budget Requirements

1. **Cost/Funding Categories** - The following local budget breakdowns are required to fulfill Family Planning grant application budget requirements each fiscal year:

   Salaries & Wages
   Fringe Benefits
   Travel
   Equipment
   Supplies
   Contractual
   Construction
   All Other Direct Costs
   Indirect Costs
   All Funding Sources by Type

   The Family Planning cost/funding categories and supporting budget detail requirements are satisfied by completion of an application budget in the MI E-Grants System. General instructions for these forms are contained at the end of this section.

2. **Costs Allowable Only With Prior Approval** - The following costs are allowable only with prior review/approval of MDHHS. Prior approval is accomplished by providing appropriate detail in the budget request approved by MDHHS or subsequently in a written request approved in writing by MDHHS.

   A. Alterations and Renovations - to change the interior arrangements or other physical characteristics of existing facilities or installed equipment, to the extent that such changes cost more than $1,000 each.

   B. Audiovisual Materials and Activities - acquired, produced, presented, or disseminated to the general public.

   C. Consultant Contracts for General Support Services - including equipment and supplies, that will cost in excess of $25,000 or 10% of the total direct cost budget (whichever is greater).

   D. Equipment - including general purpose and special equipment (e.g., air conditioning) costing $5,000 or more per unit.

   E. Insurance - contributions to a reserve for a self-insurance program.

   F. Public Information Service Costs – for the cost of providing public information services.

   G. Publication and Printing Costs - for the cost of publications.

   H. Capital Expenditures - for land or buildings.

   I. Indemnification Against Third Parties Costs - insurance against potential liabilities.

   J. Mass Severance Pay - involving grant-supported personnel.

   K. Organization/Reorganization Costs - allocable to the program.

   L. Overtime Premium - involving grant-supported personnel.

   M. Patient Care Costs - rebudgeting out of or reduction in patient care costs (considered a change in scope).

   N. Professional Services - in connection with Patent/Copyright Infringement Litigation.

O. Trailers or Modular Units – for costs of trailers and modular units.

P. Transfers Between Construction and Nonconstruction - for approved construction funds.

Q. Transfers Between Indirect and Direct Costs - for amounts awarded for indirect costs to absorb increases in direct costs.

R. Transfers for Substantive Programmatic Work - to a third party, by contracting, or any other means used for the actual performance of substantive programmatic work.

All charges to Family Planning must be necessary, reasonable, allowable, and allocable, for the proper and efficient administration of the program. Further information and cost standards are provided in federal instructions including 2 CFR, Part 225 (OMB Circular A-87), A-102 Common Rule and 2 CFR, Part 215 (OMB Circular A-110)

D. Breast and Cervical Cancer Control Coordination Program Special Budget Requirements

1. The Breast and Cervical Cancer Control Coordination Program (BCCCP) budget is to be developed in the following way:

   BCCCP Coordination should be used to budget costs associated with coordination of the program. Only coordination expenses will be reimbursed through the Comprehensive Agreement. All Direct Service claims, including Navigation Services, must be billed to the MDHHS Cancer Prevention and Control Section for claim processing. The Local Coordinating Agency (LCA) and/or direct service providers with contracts or letters of agreement with the LCA will be responsible for billing Direct Service claims to the MDHHS Cancer Prevention and Control Section. **No Direct Services or Navigation Service expenses will be reimbursed through the Comprehensive Agreement.**

   The Coordination amount $175 per woman based on a target caseload established by MDHHS.

   Performance reimbursement will be based upon the understanding that a certain level of performance (measured by outputs) must be met. There is a **97% performance requirement** for this program. There is no longer a match requirement. Match is recorded by the program and reported to MDHHS.

   For specific billing requirements refer to the most recent Billing Manual. For specific program requirements, including current fiscal year Direct Service Reimbursement Rates and documentation related to the match requirement, refer to the current fiscal year Special Budgeting and Other Program Instructions for the BCCCNP issued in August of each fiscal year. The above referenced documents are available at www.michigancancer.org/BCCCNP.

2. The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Prevention Block Grant Pilot Project budget is to be developed in the following way:

   WISEWOMAN Coordination and Screening should be used to budget costs associated with coordination of the program and delivery of the initial screening and risk reduction counseling to WISEWOMAN participants. This includes administration and interpretation of health risk

instrument, WISEWOMAN screening services (height, weight, body mass index, 2 blood pressure readings, total cholesterol, HDL cholesterol, and glucose or A1C), and delivery of risk reduction counseling.

All Direct Service claims must be billed to the MDHHS Cancer Prevention and Control Section for claim processing. The Local Coordinating Agency (LCA) and/or direct service providers with contracts or letters of agreements with the LCA will be responsible for billing Direct Service claims to the MDHHS Cancer Prevention and Control Section. This includes follow-up fasting lipid panel, fasting glucose, A1c, and one diagnostic exam. **No Direct Services expenses will be reimbursed through the Comprehensive Agreement.**

The Coordination and Screening amount is **$150** per woman based on a target caseload established by MDHHS.

Performance reimbursement will be based upon the understanding that a certain level of performance (measured by outputs) must be met. There is a **95% caseload performance requirement** for this project.

For specific billing requirements refer to the most recent Billing Manual. For specific program requirements, including current fiscal year Direct Service Reimbursement rates and documentation related to the match requirement, refer to the current fiscal year Special Budgeting and other Program instructions for the WISEWOMAN Program issued in August of each fiscal year. The above referenced documents are available at www.michigan.gov/cancer.

E. **Children's Special Health Care Services (CSHCS) Outreach and Advocacy** - The program element, titled CSHCS Outreach and Advocacy should be used to budget costs associated with this program.

I. Program Budget - Online Detail Budget Application Entry

Complete the appropriate budget forms contained within the MI E-Grants System for each program element. An example of this form is attached (see Attachment 1 for reference).

1. **Salary and Wages** -

   a. **Position Description** - Select from the expenditure row look-up all position titles or job descriptions required to staff the program. If the position is missing from the list, please use Other and type in the position in the drop down field provided.

   b. **Positions Required** - Enter the number of positions required for the program corresponding to the specific position title or description. This entry may be expressed as a decimal (e.g., Full-Time Equivalent – FTE) when necessary. If other than a full-time position is budgeted, it is necessary to have a basis in terms of time reports to support time charged to the program.

   c. **Amount** – The MI E-Grants System calculates the salary for the position required and records it on the Budget Detail. Enter this amount in the Amount column.

   d. **Total Salary** –The MI E-Grants System totals the amount of all positions required and records it on the Budget Summary.

   e. **Notes** - Enter any explanatory information that is necessary for the position description.

Include an explanation of the computation of Total Salary in those instances when the computation is not straightforward (i.e., if the employee is limited term and/or does not receive fringe benefits).

2. **Fringe Benefits** – Select from the expenditure row look-up applicable fringe benefits for staff working in this program. Enter the percentage for each. The MI E-Grants system updates the total amount for salary and wages in the unit field and calculates the fringe benefit amount. If the "Composite Rate" fringe benefit item is selected from the expenditure row look up, record the applicable fringe benefit items (i.e. FICA, Life insurance, etc.) in the "Notes" tab.

3. **Equipment** - Enter a description of the equipment being purchased (including number of units and the unit value), the total by type of equipment and total of all equipment purchases.

4. **Contractual** - Specify subcontractor(s)/subrecipient(s) working on this program, including the subcontractor's/subrecipient's address, amount by subcontractor/subrecipient and total of all subcontractor(s)/subrecipient(s). Multiple small subcontracts can be grouped (e.g., various worksite subcontracts).

5. **Supplies and Materials** - Enter amount by category. **A description is required if the budget category exceeds 10% of total expenditures.**

6. **Travel** - Enter amount by category. **A description is required if the budget category exceeds 10% of total expenditures.**

7. **Communication** - Enter amount by category. **A description is required if the budget category exceeds 10% of total expenditures.**

8. **County-City Central Services** - Enter amount by category and total for all categories.

9. **Space Costs** - Enter amount by category and total for all categories.

10. **Other Expenses** - Enter amount by category and total for all categories. **A description is required if the budget category exceeds 10% of total expenditures.**

11. **Indirect Cost Calculation** - Enter the base(s), rate(s) and amount(s).

12. **Other Cost Distributions** - Enter a description of the cost, percent distributed to this program and the amount distributed.

13. **Total Exp.** - MI E-grants totals the amount of all positions required and records it on the Budget Summary.

B1 Attachment B1-Program Budget Summary

EGrAMS Application

Budget Category Application

Agency: ABC Health Department | Program: Comprehensive Agreement - FY 20XX

Application: Family Planning Services SAMPLE | Show: Documents

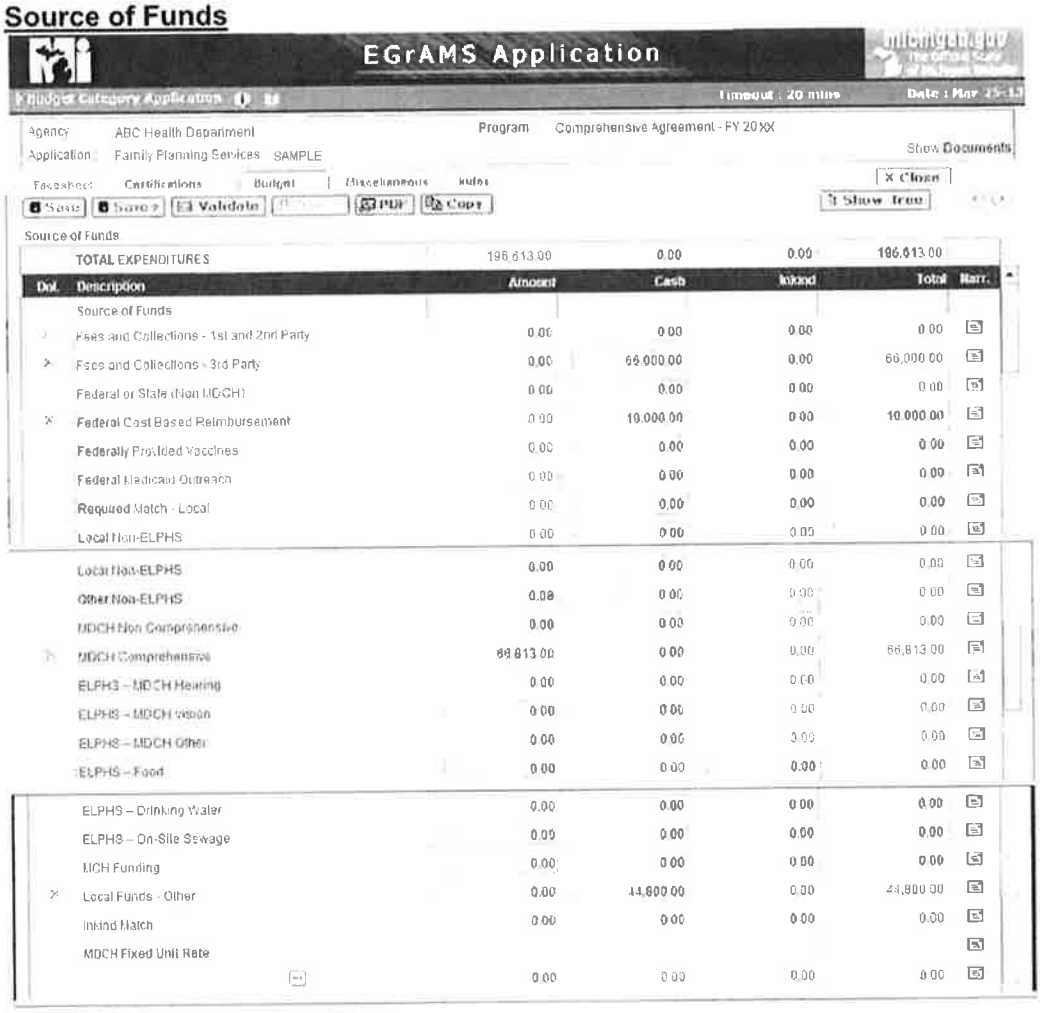
Facesheet | Certifications | Budget | Miscellaneous | Index

EJ Validate | PDF | Copy | Close | Show Tree

Budget Summary

Description	Total	Amount	Cash	Inkind	Narr.
DIRECT EXPENSES					
Program Expenses					
Salary & Wages	83,419.00	83,419.00	0.00	0.00	
Fringe Benefits	34,202.00	34,202.00	0.00	0.00	
Cap. Exp. for Equip & Fac.					
Contractual					
Supplies and Materials	23,275.00	23,275.00	0.00	0.00	
Travel	3,340.00	3,340.00	0.00	0.00	
Communication	7,282.00	7,282.00	0.00	0.00	
County-City Central Services					
Space Costs	10,131.00	10,131.00	0.00	0.00	
All Others (ADP, Con. Employees, Misc.)	3,884.00	3,884.00	0.00	0.00	
Total Program Expenses	165,523.00	165,523.00	0.00	0.00	
TOTAL DIRECT EXPENSES	165,523.00	165,523.00	0.00	0.00	
INDIRECT EXPENSES					
Indirect Costs					
Indirect Costs	29,405.00	29,405.00	0.00	0.00	
Other Costs Distributions	1,685.00	1,685.00	0.00	0.00	
Total Indirect Costs	31,090.00	31,090.00	0.00	0.00	
TOTAL INDIRECT EXPENSES	31,090.00	31,090.00	0.00	0.00	
TOTAL EXPENDITURES	196,613.00	196,613.00	0.00	0.00	

Source of Funds



EGrAMS Application

Budget Category Application

Timeout : 20 mins

Agency ABC Health Department

Program Comprehensive Agreement - FY 20XX

Application Family Planning Services SAMPLE

Show Documents

Facesheet | Certifications | Budget | Miscellaneous | Notes

Close

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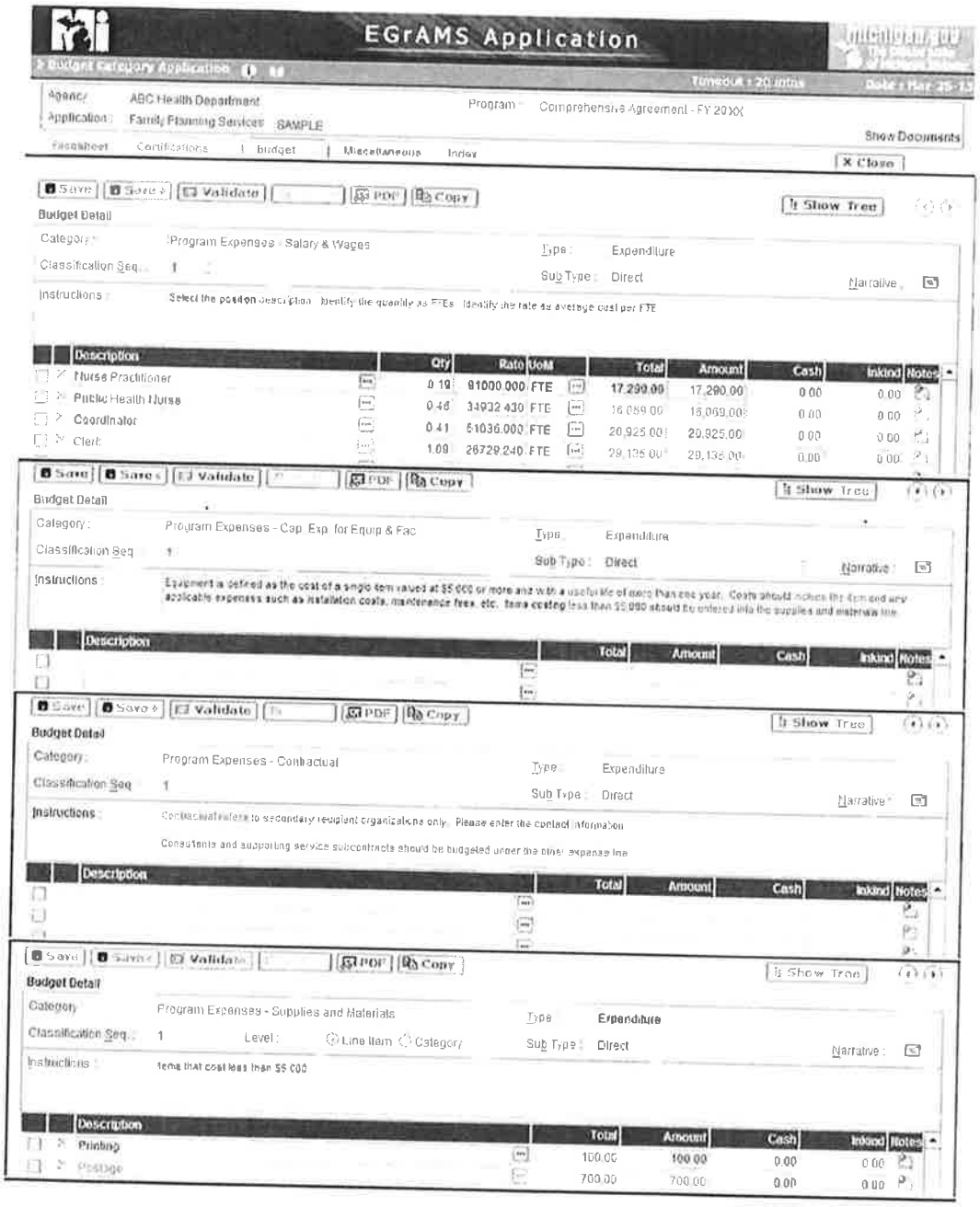
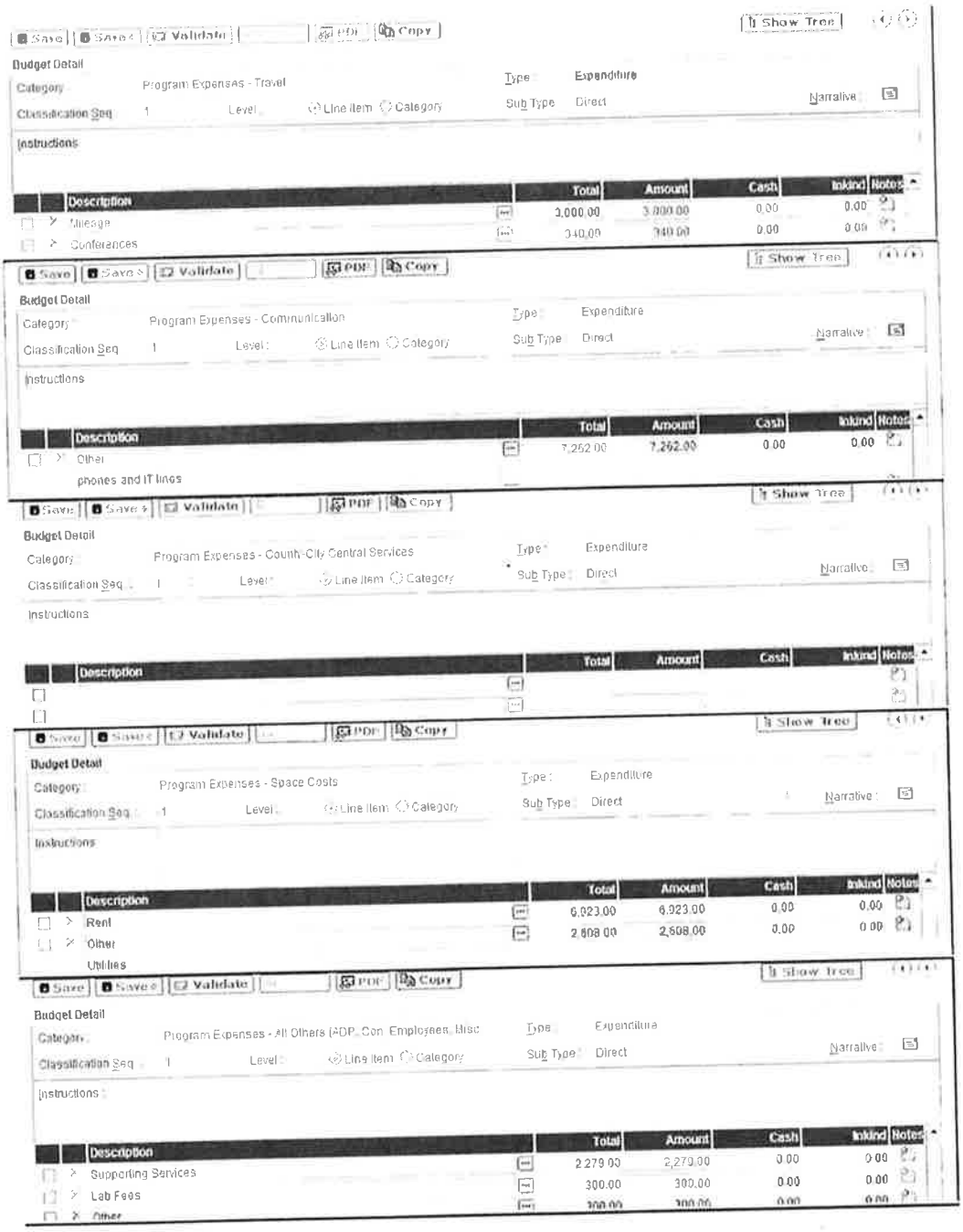
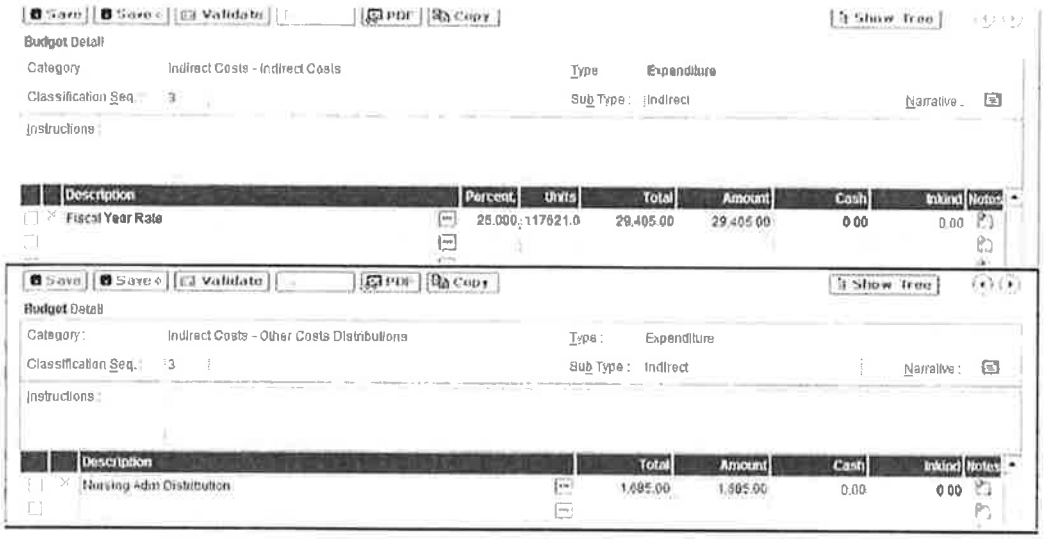
Source of Funds

	TOTAL EXPENDITURES	166,613.00	0.00	0.00	166,613.00	
Del.	Description	Amount	Cash	Inkind	Total	Narr.
	Source of Funds					
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00	
*	Fees and Collections - 3rd Party	0.00	66,000.00	0.00	66,000.00	
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00	
*	Federal Cost Based Reimbursement	0.00	10,000.00	0.00	10,000.00	
	Federally Provided Vaccines	0.00	0.00	0.00	0.00	
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00	
	Required Match - Local	0.00	0.00	0.00	0.00	
	Local Non-ELPHS	0.00	0.00	0.00	0.00	
	Local Non-ELPHS	0.00	0.00	0.00	0.00	
	Other Non-ELPHS	0.00	0.00	0.00	0.00	
	MDCH Non Comprehensive	0.00	0.00	0.00	0.00	
*	MDCH Comprehensive	66,613.00	0.00	0.00	66,613.00	
	ELPHS – MDCH Hearing	0.00	0.00	0.00	0.00	
	ELPHS – MDCH Vision	0.00	0.00	0.00	0.00	
	ELPHS – MDCH Other	0.00	0.00	0.00	0.00	
	ELPHS – Food	0.00	0.00	0.00	0.00	
	ELPHS – Drinking Water	0.00	0.00	0.00	0.00	
	ELPHS – On-Site Sewage	0.00	0.00	0.00	0.00	
	MCH Funding	0.00	0.00	0.00	0.00	
*	Local Funds - Other	0.00	44,800.00	0.00	44,800.00	
	Inkind Match	0.00	0.00	0.00	0.00	
	MDCH Fixed Unit Rate					
		0.00	0.00	0.00	0.00	

B2 Attachment B2-Program Budget Cost Detail




Save
Save &
Validate
PDF
Copy
Show Tree
Budget Detail
Category: Program Expenses - Travel
Type: Expenditure
Classification Seq: 1
Level: Line Item Category
Sub Type: Direct
Narrative:
Instructions
Description
Total
Amount
Cash
Inkind
Notes
Mileage
3,000.00
3,000.00
0.00
0.00
Conferences
340.00
340.00
0.00
0.00
Budget Detail
Category: Program Expenses - Communication
Type: Expenditure
Classification Seq: 1
Level: Line Item Category
Sub Type: Direct
Narrative:
Instructions
Description
Total
Amount
Cash
Inkind
Notes
Other
phones and IT lines
7,262.00
7,262.00
0.00
0.00
Budget Detail
Category: Program Expenses - County City Central Services
Type: Expenditure
Classification Seq: 1
Level: Line Item Category
Sub Type: Direct
Narrative:
Instructions
Description
Total
Amount
Cash
Inkind
Notes
Budget Detail
Category: Program Expenses - Space Costs
Type: Expenditure
Classification Seq: 1
Level: Line Item Category
Sub Type: Direct
Narrative:
Instructions
Description
Total
Amount
Cash
Inkind
Notes
Rent
6,923.00
6,923.00
0.00
0.00
Other
Utilities
2,508.00
2,508.00
0.00
0.00
Budget Detail
Category: Program Expenses - All Others (ADP, Con Employees, Misc
Type: Expenditure
Classification Seq: 1
Level: Line Item Category
Sub Type: Direct
Narrative:
Instructions
Description
Total
Amount
Cash
Inkind
Notes
Supporting Services
2,279.00
2,279.00
0.00
0.00
Lab Fees
300.00
300.00
0.00
0.00
Other
300.00
300.00
0.00
0.00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Category
Indirect Costs - Indirect Costs
Type
Expenditure
Classification Seq.
3
Sub Type :
Indirect
Narrative :
Instructions :
Description
Percent
Units
Total
Amount
Cash
Inkind
Notes
Fiscal Year Rate
25.000
117621.0
29,405.00
29,405.00
0.00
0.00
Save
Save
Validate
PDF
Copy
Show Tree
Budget Detail
Category :
Indirect Costs - Other Costs Distributions
Type :
Expenditure
Classification Seq. :
3
Sub Type :
Indirect
Narrative :
Instructions :
Description
Total
Amount
Cash
Inkind
Notes
Nursing Adm Distribution
1,695.00
1,695.00
0.00
0.00

F. Medicaid Outreach Activities Reimbursement Procedures

Medicaid Outreach Activities that are funded by local dollars and meet federal requirements are eligible for reimbursement at a 50% federal administrative match rate. Local Health Departments seeking reimbursement for the provision of locally funded allowable outreach activities specific to the Medicaid program may do so by submitting appropriate documentation to MDHHS in accordance with the instructions listed below. Medicaid Outreach Activities funding is a subrecipient relationship.

I. Budget Preparation

A. Medicaid Outreach Activities

Complete the MI E-Grants application and budget forms for the application **Medicaid Outreach Activities** that occur during the fiscal year: 10/1/xx-09/30/xx. Reimbursable activities included in the budget must conform to the requirements as specified in the MSA Bulletin 05-29. Complete the MI E-Grants application and budget forms for this program.

1. Expenditure Category Tab

   Enter the expenditures budgeted for the fiscal year: 10/01/xx-09/30/xx. Expenses budgeted for each of the listed expenditure categories are allowable and must be specific to the Medicaid program as described in MSA Bulletin 05-29 s. Outreach activities must not be part of direct service. Expenditures must be reflected in the cost allocation plan.

2. Source of Funds Tab

   Budget the amount expected from the federal government for allowable Medicaid Outreach Activities. **Federal Medicaid Outreach** represents the anticipated 50% federal administrative match of local contributions. Budget the local contribution. **Required Match - Local** represents the 50% matching local contribution for Medicaid Outreach activities. **These two amounts must match.**

3. Sources of Local Funds Types

   Local Health Departments may utilize their county appropriation, funds received from local or private foundations, local contributors or donators, and from other non-state/non-federal grant agreements that are specific to Medicaid outreach or are to be used at the discretion of the Health Department as a source for matching funds. Other state and/or federal grant awards for Medicaid Outreach must be recorded on the appropriate line as indicated in the Comprehensive Budget Instructions - Attachment I. (Please specify the source of funds as shown in the example.)

B. Nurse-Family Partnership Outreach (applicable only for Berrien, Calhoun, Ingham, Kalamazoo, Kent, Oakland, and Saginaw)

Complete the MI E-Grants application and budget forms for the application titled **Nurse-Family Partnership** Medicaid Outreach for the timeframe: 10/01/xx-09/30/xx. Complete the MI E-Grants application and budget forms for this program.

Expenditures related to Nurse-Family Partnership Medicaid Outreach should be reflected under one program element and adhere to Section VIII, Special Budget Instructions section found in the Comprehensive Budget Instructions - Attachment I. The budget should reflect the entire fiscal year period: 10/1/xx-09/30/xx.

1. **Federal Medicaid Outreach**

   Fifty percent (50%) of local funds after the percentage of Medicaid clients enrolled in the LHD Nurse-Family Partnership program has been applied. The formula for calculating the federal funding is as follows:

   Federal funding = (Local funds x % of Medicaid Participation Rate) x 50% Federal Administrative Match rate)

2. **Required Match - Local**

   Represents the 50% match of local contributions. Budget the local match contribution in Required Match – Local. Federal Medicaid Outreach and Required Match – Local ~~should~~ must equal each other. **Additional local contribution related to service provision for non-Medicaid eligible participants which are not eligible for the 50% federal match should be reported in Local Funds – Other.**

3. **Sources of Local Fund Types**

   Local Health Departments may utilize their county appropriation, funds received from local or private foundations, local contributors or donators, and from other non-state/non-federal grant agreements that are specific to Medicaid Outreach or are to be used at the discretion of the Health Department as a source for matching funds.

C. CSHCS Medicaid Outreach

Complete the MI E-Grants application and budget forms for the application titled **CSHCS Medicaid Outreach** for the timeframe: 10/01/xx-09/30/xx.

1. Expenditures related to CSHCS Medicaid Outreach should be reflected under one program element and adhere to Section IV, Special Instruction Section found in the Comprehensive Budget Instructions - Attachment I. The budget should reflect the entire fiscal year period: 10/1/xx-09/30/xx.

   a. **Federal Medicaid Outreach**

      Fifty percent (50%) of local funds after the percentage of Medicaid clients enrolled in the LHD CSHCS program has been applied. A table containing each health jurisdiction Medicaid Participation Rate is located in the MI E-Grants site. The formula for calculating the federal funding is as follows:

      Federal funding = (Local funds x % of Medicaid Participation Rate) x 50% Federal Administrative Match rate)

   b. **Required Match - Local**

      Represents the 50% match of local contributions. Budget the local match contribution. Federal Medicaid Outreach and Required Match – Local must equal each other. **Additional local contribution that is not eligible for the 50% federal match should be reported on the Local Funds – Other line.Sources of Local Fund Types**

      Local Health Departments may utilize their county appropriation, funds received from local or private foundations, local contributors or donators, and from other non-state/non-federal grant agreements that are specific to Medicaid Outreach or are to be used at the discretion of the health department as a source for matching funds.

1. Comprehensive CSHCS Outreach and Advocacy and Case Management/Care Coordination Funds

   Should be reported in a separate program element.

2. **Cost Distributions**

   Record costs distributions in the Indirect Costs – Other Costs Distribution on the Application budget if costs associated with allowable Medicaid Outreach activities conducted in other Comprehensive programs (i.e., WIC, Family Planning, Immunization, etc.) are to be distributed. This may require a budget modification in the related program(s) to reflect the cost distribution movement.

3. **Cost Allocation Certification**

   This certification remains on file with the Department until no longer valid (see Sample 2). Any changes in the Cost Allocation Plan (See Sample 3) requires the Cost Allocation certification to be updated.

4. **Cost Allocation Plan for Medicaid Outreach Activities**

   A cost allocation plan is a way to identify costs associated with providing Medicaid Outreach. The plan includes both direct and indirect costs. The plan should describe how costs are determined and allocated or distributed to assure the costs are being assigned to the correct program. The cost allocation plan should also identify any non-reimbursable costs. Cost allocation plans are a requirement for receiving federal awards. The agency must retain a copy on file and make available for review upon request. (Sample 2)

   For FY 2016, LHDs must submit a copy of their cost allocation plan with the budget request. The allocation plan is to be attached to an expenditure line on the Medicaid Outreach budget.

II. Financial Status Report (FSR) – LHDs seeking 50% federal administrative match should request reimbursement by submitting their actual expenses for allowable Medicaid Outreach activities on their quarterly FSRs through MI E-Grants.

A. Medicaid Outreach Activities

For Quarters 1-3, LHDs must reflect the actual Medicaid Outreach expenses incurred in a separate program element titled Medicaid Outreach. Actual expenses incurred for each of the listed expenditure categories are allowable, but must be specific to Medicaid Outreach as defined by the MSA Bulletin 05-29 and not part of a direct service. Expenses should be supported by an approved methodology.

1. Federal Medicaid Outreach

   Should be used to request the 50% federal administrative match for Medicaid Outreach.

2. Required Match - Local

   Should be used to report the remaining portion of the local contribution of the Medicaid Outreach Match. Both amounts should equal.

3. Source of Funds Category

   Other source of funds that are non-reimbursable for Medicaid Outreach (i.e., other federal grants, other MDHHS grants, etc.) should be reported on the appropriate

line has indicated in the Comprehensive Budget Instructions - Attachment I (e.g., Local non-ELPHS or Local Funds – Other).

Total Source of Funds must equal **Total Expenditures.**

B. Nurse-Family Partnership Medicaid Outreach – Quarterly and Final FSRs

For Quarters 1-3, LHDs must reflect the actual Medicaid Outreach expenses incurred in a separate program element titled Medicaid Outreach. Actual expenses incurred for each of the listed expenditure categories are allowable, but must be specific to Medicaid Outreach as defined by MSA Bulletin 05-29 and not part of a direct service. Expenses should be supported by a time study or other federally approved methodology.

1. Federal Medicaid Outreach

   Should be used to request the 50% federal administrative match. Match is determined by multiplying local contribution for the program by the percentage of Medicaid enrollees. This product is then multiplied by 50% in order to determine the eligible federal administrative match.

2. Required Match - Local

   Should be used to report the remaining portion of the local contribution for the Medicaid Outreach Match. Both lines should equal. **Additional local contribution related to service provision for non-Medicaid eligible participants which are not eligible for the 50% federal match should be reported in Local Funds - Other.**

3. Source of Funds Category

   Other source of funds that are non-reimbursable for Medicaid Outreach (i.e., other federal grants, other MDHHS grants, etc.) should be reported on the appropriate line has indicated in the Comprehensive Budget Instructions - Attachment I (e.g., Local non-ELPHS or Local Funds – Other).

C. CSHCS Medicaid Outreach – Final FSR

CSHCS Medicaid Outreach billing should occur on the final FSR through the MI E-Grants system after Comprehensive Agreement CSHCS Outreach and Advocacy funds have been expended.

1. Federal Medicaid Outreach

   Should be used to request the 50% federal administrative match. Match is determined by multiplying local contribution for the program by the percentage of Medicaid enrollees. This product is then multiplied by 50% in order to determine the eligible federal administrative match.

2. Required Match - Local

   Should be used to report the remaining portion of the local contribution for the Medicaid Outreach Match. **Additional local contribution that is not eligible for the 50% federal match should be reported in Local Funds - Other.**

3. Source of Funds Category

   Other source of funds that are non-reimbursable for Medicaid Outreach (i.e., other federal grants, other MDHHS grants, etc.) should be reported on the appropriate line has indicated in the Comprehensive Budget Instructions - Attachment I.

4. Comprehensive CSHCS Outreach and Advocacy and Care Coordination

   Should be billed as separate program element.

III. Comprehensive Agreement Obligation Report – filed in September 20xx.

The Obligation report is used to estimate the payable amount due to Local Health Departments from MDHHS for each program element.

A. In the Estimate Column, enter the maximum projected federal administrative match earnings for allowable Medicaid Outreach Activities to be earned from Medicaid Outreach on the Federal Medicaid Outreach row.

B. In the Estimate Column, enter the maximum projected federal administrative match earnings for allowable Medicaid Outreach activities to be earned from CSHSC – Medicaid Outreach. This should reflect the local contribution multiplied by the Medicaid enrollment participation rate x 50% federal match rate.

C. In the Estimate Column, enter the maximum projected federal administrative match earnings for allowable Medicaid Outreach activities to be earned from Nurse Family Partnership Outreach. This should reflect the local contribution multiplied by the Medicaid enrollment participation rate x 50% federal match rate.

Note: CSHCS Outreach and Advocacy and CSHCS Care Coordination activities funded through the Comprehensive Agreement are recorded as separate program elements.

Example 1

Medicaid Outreach Cost Allocation Plan

Orange County Health Department

Cost Allocation Methodology
For Medicaid Outreach Activities

Orange County Health Department allocated costs for Medicaid Outreach as follows:

Salaries & Fringes: Distributed based on the actual amount of time each employee spends in each program for which they work. Vacation/sick/holiday pay is allocated in the same manner.

Supplies and Materials: Directly expensed to the specific program(s) identified by the employee as needed. Costs that benefit all programs will be allocated based on percentage staff in each program.

Travel: All travel costs are charged directly to the program for which the travel was incurred.

Communications: Distributed based on the percentage of time staff worked in each program.

Space Costs: Distributed based on the square footage used by the FTE and the percentage of time they worked in each program. Common area square footage is allocated based on percentage staff in each program.

All Others: (Translation services, miscellaneous services, insurances, dues, etc...) Costs are charged directly to the program for which the service occurred.

Indirect costs: distributed across all programs based on the salaries and fringes of staff in each program.

Example 2

Orange County Health Department

Medicaid Outreach Cost Allocation Methodology Certification

This is to certify that I have reviewed the cost allocation plan and to the best of my knowledge and belief that:

1. All costs contained in this proposal to establish cost allocations or billings for Medicaid Outreach Activities are allowable in accordance with the requirements of Title 2 CFR Part 200, "Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards," and the federal and state awards to which they apply. Unallowable costs have been adjusted for in allocating costs as indicated in the cost allocation plan.

2. All costs included in this proposal are properly allocable to the Medicaid Outreach Activities Administration award on a basis of a beneficial causal relationship between the expenses incurred and the Medicaid Outreach Administration award to which they are allocated in accordance with applicable requirements. Further, the same costs that have been treated as indirect costs have not been claimed as direct costs. Similar types of costs have been accounted for consistently.

3. This certification will be resubmitted if a significant change occurs that impacts the Medicaid Outreach activities or upon a Department review that results in a finding of non-compliance. If neither of these conditions exists, the certification remains valid in subsequent fiscal years.

I declare that the foregoing is true and correct:

Health Department: _____

Signature: _____

Name of Official: _____

Title: _____

Date: _____

An authorized official of the organization must certify that the plan has been prepared in accordance with authorizing legislation and regulations, and state or other applicable requirements. Every cost allocation plan must include a certification.

ORANGE COUNTY HEALTH DEPARTMENT
Budgeted Costs for Medicaid Outreach Activities

1 *Program Budget Summary*

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Medicaid Outreach			DATE PREPARED 08/17/2015			
CONTRACTOR NAME Orange County Health Department			BUDGET PERIOD From : 10/1/2015 To : 9/30/2016			
MAILING ADDRESS (Number and Street) 123 Acme Rd.			BUDGET AGREEMENT Original Amendment		AMENDMENT # 0	
CITY Orangegrove	STATE MI	ZIP CODE 49555	FEDERAL ID NUMBER 38-5555555			
	Category		Amount	Cash	In-kind	Total
DIRECT EXPENSES						
Program Expenses						
1	Salary & Wages		153,556.00	0.00	0.00	153,556.00
2	Fringe Benefits		71,204.00	0.00	0.00	71,204.00
3	Cap. Exp. for Equip & Fac.		0.00	0.00	0.00	0.00
4	Contractual		0.00	0.00	0.00	0.00
5	Supplies and Materials		2,500.00	0.00	0.00	2,500.00
6	Travel		500.00	0.00	0.00	500.00
7	Communication		5,000.00	0.00	0.00	5,000.00
8	County-City Central Services		0.00	0.00	0.00	0.00
9	Space Costs		8,000.00	0.00	0.00	8,000.00
10	All Others (ADP, Con. Employees, Misc.)		4,500.00	0.00	0.00	4,500.00
Total Program Expenses			245,260.00	0.00	0.00	245,260.00
TOTAL DIRECT EXPENSES			245,260.00	0.00	0.00	245,260.00
INDIRECT EXPENSES						
Indirect Costs						
1	Indirect Costs		37,220.00	0.00	0.00	37,220.00
2	Other Costs Distributions		35,000.00	0.00	0.00	35,000.00
Total Indirect Costs			72,220.00	0.00	0.00	72,220.00
TOTAL INDIRECT EXPENSES			72,220.00	0.00	0.00	72,220.00
TOTAL EXPENDITURES			317,480.00	0.00	0.00	317,480.00

2 Program Budget - Source of Funds

	Source of Funds				
	Category	Amount	Cash	Inkind	Total
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	158,740.00	0.00	0.00	158,740.00
	Required Match - Local	0.00	158,740.00	0.00	158,740.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDCH Non Comprehensive	0.00	0.00	0.00	0.00
	MDCH Comprehensive	0.00	0.00	0.00	0.00
	ELPHS - MDCH Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDCH Vision	0.00	0.00	0.00	0.00
	ELPHS - MDCH Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Drinking Water	0.00	0.00	0.00	0.00
	ELPHS - On-Site Sewage	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDCH Fixed Unit Rate				
	Totals	158,740.00	158,740.00	0.00	317,480.00

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	UOM	Amount	Cash	Inkind	Total
DIRECT EXPENSES								
Program Expenses								
1	Salary & Wages							
	Public Health Nurse	1.0370	54,545.00	FTE	56,563.17	0.00	0.00	56,563
	Social Worker	0.2800	51,876.00	FTE	14,525.28	0.00	0.00	14,525
	Technician	0.5650	40,650.00	FTE	23,700.25	0.00	0.00	23,730
	Health Educator	0.5550	50,955.00	FTE	28,280.03	0.00	0.00	28,280
	Clerical	0.4850	34,071.00	FTE	16,524.44	0.00	0.00	16,524
	Supervisor	0.2200	63,102.00	FTE	13,882.44	0.00	0.00	13,882
Total for Salary & Wages					153,555.80	0.00	0.00	153,556
2	Fringe Benefits							
	All Composite Rate Notes: FICA, FUTA, LIFE, HEALTH DENTAL/VISION, PENSION, UNEMPLOYMENT, WORKMANS COMP.	0.0000	46.370		71,203.73	0.00	0.00	71,204
3	Cap. Exp. for Equip & Fac.							
4	Contractual							
5	Supplies and Materials							
	Printing				750.00	0.00	0.00	750.00
	Office Supplies				1,250.00	0.00	0.00	1,250.00
	Postage				500.00	0.00	0.00	500.00
6	Travel							
	Mileage				500.00	0.00	0.00	500.00
7	Communication							
	Telephone, Cell				5,000.00	0.00	0.00	5,000.00
8	County-City Central Services							
9	Space Costs							
	Space Costs				8,000.00	0.00	0.00	8,000.00
10	All Others (ADP, Con. Employees, Misc.)							
	Translation Services				4,000.00	0.00	0.00	4,000.00
	Miscellaneous				500.00	0.00	0.00	500.00

Total Program Expenses					245,260.00	0.00	0.00	245,260.00
TOTAL DIRECT EXPENSES					245,260.00	0.00	0.00	245,260.00
INDIRECT EXPENSES								
Indirect Costs								
1	Indirect Costs							
	Fiscal Year Rate	0.0000	16.560		37,220.15	0.00	0.00	37,220
2	Other Costs Distributions							
	Nursing Admin Distribution		0.00	0.00	35,000.00	0.00	0.00	35,000
Total Indirect Costs					72,220.15	0.00	0.00	72,220
TOTAL INDIRECT EXPENSES					72,220.15	0.00	0.00	72,220
TOTAL EXPENDITURES					317,480.15	0.00	0.00	$317,480

H. Michigan Colorectal Cancer Screening Program – The Michigan Colorectal Cancer Early Detection program (MCRCEDP) budget is to be developed in the following ways:

1. This budget is intended to cover all staffing and coordination for the program. All allowable expenses will be reimbursed through the Comprehensive Agreement.

1. All direct service claims must be billed through the MDHHS Cancer Prevention and Control Section. The LHD and/or direct service providers with contracts or letters of agreement with the LHD will be responsible for billing.

2. The staffing, coordination and direct service total amount is $105 per woman or man based on a target caseload established by MDHHS. Performance reimbursement will be based upon the understanding that a certain level of performance (measured by outputs) must be met. There is a 90% performance requirement for this program. The performance target output measure is the number of women and men that complete a screening test for colorectal cancer.

3. For specific program requirements, including current direct service reimbursement rates and other documentation refer to the most current MCRCEDP manual.

Allowable Uses of 317 and VFC FA Operations Funds

POB developed the following table to assist awardees in preparing budgets that are in compliance with federal grants policies and CDC award requirements. The table was developed using a combination of OMB Circular A-87, PHS Grants Policy Statement 9505, and POB-identified program priorities.

Object Class Category/Expenses	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC/AFIX funds	Allowable with Pan Flu funds	Allowable with VFC Distribution funds *(where applicable)*
Personnel						
Salary/wages	✓	✓	✓	✓	✓	✓
Fringe						
Compensation/fringe benefits	✓	✓	✓	✓	✓	✓
Travel						
State/local/Regional conference travel expenses	✓	✓		✓	✓	
Local meetings/conferences (Ad hoc) (excluding meals)	✓	✓		✓	✓	
In-state travel costs	✓	✓		✓	✓	
Out of state travel costs (e.g. NIC, Hep B Coordinator's Meeting, Program Managers/PHA Meeting, ACIP meetings, AFIX and VFC trainings, Program Managers Orientation, and other CDC-sponsored immunization program meetings)*	✓	✓ *(VFC-related)*		✓ *(VFC-related)*	✓ *(preparedness-related)*	
*Please refer to Operations Funding Categories, pg.10 – 11 for additional information.						
VFC-only site visits	✓	✓		✓		
AFIX-only site visits	✓			✓		

Object Class Category/Expenses	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC/AFIX funds	Allowable with Pan Flu funds	Allowable with VFC Distribution funds *(where applicable)*
Combined (AFIX & VFC site visits)	✓	✓		✓		
Perinatal hospital record reviews	✓					
Equipment*						
Fax machines for vaccine ordering	✓	✓	✓			
Vaccine storage equipment for VFC vaccine	✓	✓				✓ *(for distribution locations)*
Copy machines	✓	✓	✓	✓	✓	✓
Equipment: an **article of tangible nonexpendable personal property having useful life of more than one year **and** an acquisition cost of **$5,000 or more** per unit.*						
Supplies						
Vaccine administration supplies (including, but not limited to, nasal pharyngeal swabs, syringes for emergency vaccination clinics)	✓					
Office supplies-computers, general office (pens, paper, paper clips, etc.), ink cartridges, calculators	✓	✓	✓	✓	✓	✓
Personal computers / Laptops / Tablets	✓	✓	✓	✓	✓	✓
Pink Books, Red Books, Yellow Books	✓					
Printers	✓	✓	✓	✓	✓	✓
Laboratory supplies (influenza cultures and PCRs, cultures and molecular, lab media serotyping)	✓					
Digital data logger with valid certificate of calibration/validation/testing report	✓	✓				✓
Vaccine shipping supplies (storage containers, ice packs, bubble wrap, etc.)						✓

Object Class Category/Expenses	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC/AFIX funds	Allowable with Pan Flu funds	Allowable with VFC Distribution funds *(where applicable)*
Contractual						
State/local conferences expenses (conference site, materials printing, hotel accommodations expenses, speaker fees) *Food is not allowable.*	✓	✓			✓	
Regional/Local meetings	✓	✓		✓	✓	
General contractual services (e.g., IAPs, local health departments, contractual staff, advisory committee media, provider trainings)	✓	✓	✓	✓	✓	
GSA Contractual services	✓	✓				
Other IIS contractual agreements (support, enhancement, upgrades)	✓	✓			✓	
FA						
Non-CDC Contract vaccines	✓					
Indirect						
Indirect costs	✓	✓	✓	✓	✓	✓
Miscellaneous						
Accounting services	✓	✓				
Advertising (restricted to recruitment of staff or trainees, procurement of goods and services, disposal of scrap or surplus materials)	✓	✓				
Audit Fees	✓	✓				
BRFSS Survey	✓					
Committee meetings (room rental, equipment rental, etc.)	✓	✓			✓	
Communication (electronic/computer						

Object Class Category/Expenses	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC/AFIX funds	Allowable with Pan Flu funds	Allowable with VFC Distribution funds *(where applicable)*
transmittal, messenger, postage, local and long distance telephone)	✓	✓	✓	✓	✓	
Consumer information activities	✓	✓			✓	
Consumer / provider board participation (travel reimbursement)	✓					
Data processing	✓	✓	✓	✓	✓	
Laboratory services (tests conducted for immunization programs)	✓					
Local service delivery activities	✓					
Maintenance operation/repairs	✓					
Malpractice insurance for volunteers	✓					
Memberships/subscriptions	✓					
NIS Oversampling	✓					
Pagers/cell phones	✓	✓		✓	✓	
Printing of vaccine accountability forms	✓	✓				
Professional service costs directly related to immunization activities (limited term staff), Attorney General Office services	✓					
Public relations	✓				✓	
Publication/printing costs (all other immunization related publication and printing expenses)	✓	✓		✓	✓	
Rent (requires explanation of why these costs are not included in the indirect cost rate agreement or cost allocation plan)	✓	✓				✓ *(for vaccine distribution facility)*
Shipping (other than vaccine)	✓	✓				
Shipping (vaccine)						✓
Software license/Renewals (ORACLE, etc.)	✓					
Stipend Reimbursements	✓					

Object Class Category/Expenses	Allowable with 317 operations funds	Allowable with VFC operations funds	Allowable with VFC ordering funds	Allowable with VFC/AFIX funds	Allowable with Pan Flu funds	Allowable with VFC Distribution funds *(where applicable)*
Toll-free phone lines for vaccine ordering	✓	✓	✓			
Training costs – Statewide, staff, providers	✓	✓		✓	✓	
Translations (translating materials)	✓					
Vehicle lease (restricted to awardees with policies that prohibit local travel reimbursement)	✓					
VFC enrollment materials	✓	✓				
VFC provider feedback surveys	✓	✓				
VIS camera-ready copies	✓					

Non-Allowable Expenses with Federal Immunization Funds

Expense	NOT allowable with federal immunization funds
Honoraria	✓
Advertising costs *(e.g., conventions, displays, exhibits, meetings, memorabilia, gifts, souvenirs)*	✓
Alcoholic beverages	✓
Building purchases, construction, capital improvements	✓
Land purchases	✓
Legislative/lobbying activities	✓
Bonding	✓
Depreciation or use charges	✓
Research	✓
Fundraising	✓
Interest on loans for the acquisition and/or modernization of an existing building	✓
Clinical care *(non-immunization services)*	✓
Entertainment	✓
Payment of bad debt	✓
Dry cleaning	✓
Vehicle Purchase	✓
Promotional Materials *(e.g., plaques, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, conference bags)*	✓
Purchase of food *(unless part of required travel per diem costs)*	✓

Other restrictions which must be taken into account while writing the budget:

Funds may be spent only for activities and personnel costs that are directly related to the Immunization and Vaccines for Children Cooperative Agreement. Funding requests not directly related to immunization activities are outside the scope of this cooperative agreement program and will not be funded.

Pre-award costs will not be reimbursed.

7/1/2014

Section I – The Basics p.25
IPOM 2015

Attachment 10

Agreement Between

Michigan Department of Health and Human

hereinafter referred to as the "Department"

and

City of Detroit

hereinafter referred to as the "Local Governing Entity"

on Behalf of Health Department

City of Detroit Department of Health and Wellness
City Treasurer 1151 Taylor Ste 333-C
Detroit MI 48202 1732
Federal I.D.#: 38-6004606, DUNS #: 006530661
hereinafter referred to as the "Grantee"
for
The Delivery of Public Health Services under
the Comprehensive Agreement

Part I

1. Purpose

This agreement is entered into for the purpose of setting forth a joint and cooperative Grantee/Department relationship and basis for facilitating the delivery of public health services to the citizens of Michigan under their jurisdiction, as described in the attached Annual Budget, established Minimum Program Requirements, and all other applicable Federal, State and Local laws and regulations pertaining to the Grantee and the Department. Public health services to be delivered under this agreement include Essential Local Public Health Services (ELPHS) and Categorical Programs as specified in the attachments to this agreement.

2. Period of Agreement:

This agreement shall commence on October 1, 2015 and continue through September 30, 2016. This agreement is full force and effect for the period specified. The Department has the option to assume no responsibility for costs incurred by the Grantee prior to the signing of this agreement.

3. Program Budget and Agreement Amount

A. Agreement Amount

In accordance with Attachment IV - Funding/Reimbursement Matrix, the total State budget and amount committed for this period for the program elements covered by this agreement is $8,561,448.00.

5. **Statement of Work**

The Grantee agrees to undertake, perform and complete the services described in Attachment III - Program Specific Assurances and Requirements and the other applicable attachments to this agreement which are part of this agreement through reference.

6. **Method of Payments and Financial Reports**

The payment procedures shall be followed as described in Part II and Attachment I - Annual Budget and Attachment IV - Funding/Reimbursement Matrix, which are part of this agreement through reference.

7. **Performance/Progress Report Requirements**

The progress reporting methods, as applicable, shall be followed as described in IV - Funding/Reimbursement Matrix, which are part of this agreement through reference.

8. **General Provisions**

The Grantee agrees to comply with the General Provisions outlined in Part II, which are part of this agreement through reference.

9. **Administration of the Agreement**

The person acting for the Department in administering this agreement (hereinafter referred to as the Contract Consultant) is:

Name:	May Alkhafaji	Brenda Roys
Title:	Departmental Analyst	Departmental Analyst
Telephone No.:	517-241-0176	517-373-1207
E-Mail Address	alkhafajim@michigan.gov	roysb@michigan.gov

10. **Special Conditions**

A. This agreement is valid upon approval by the State Administrative Board as appropriate and approval and execution by the Department.

B. The Department and Grantee, under the terms of this agreement shall, subject to availability of funding and other applicable conditions, provide resources and continuous services throughout the period of this agreement as shown in Attachment I - Annual Budget.

C. The Department will not assume any responsibility or liability for costs incurred by the Grantee prior to the signing of this agreement.

D. The Grantee is required by PA 533 of 2004 to receive payments by electronic funds transfer.

11. **Contingencies**

The Department's obligations under this agreement are conditioned on all of the following:

A. Grantee's correction of current deficiencies and achievement of Department's final approval of Grantee's Plan of Organization as required by section 2431 of the Public Health Code, MCL 333.2431.

12. Special Certification

The individual or officer signing this agreement certifies by his or her signature that he or she is authorized to sign this agreement on behalf of the responsible governing board, official or Grantee.

13. Signature Section

For City of Detroit Department of Health and Wellness

Abdulrahman El-Sayed	Executive Director
Name	Title

For the Michigan Department of Health and Human Services

Kim Stephen	10/01/2015
Kim Stephen, Director Bureau of Purchasing	Date

C. **Program Operation**

Provide the necessary administrative, professional, and technical staff for operation of the program.

D. **Reporting**

Utilize all report forms and reporting formats required by the Department at the effective date of this agreement, and provide the Department with timely review and commentary on any new report forms and reporting formats proposed for issuance thereafter.

E. **Record Maintenance/Retention**

Maintain adequate program and fiscal records and files, including source documentation to support program activities and all expenditures made under the terms of this agreement, as required. Assure that all terms of the agreement will be appropriately adhered to and that records and detailed documentation for the project or program identified in this agreement will be maintained for a period of not less than three (3) years from the date of termination, the date of submission of the final expenditure report or until litigation and audit findings have been resolved.

F. **Authorized Access**

Permit upon reasonable notification and at reasonable times, access by authorized representatives of the Department, Federal Grantor Agency, Comptroller General of the United States and State Auditor General, or any of their duly authorized representatives, to records, files and documentation related to this agreement, to the extent authorized by applicable state or federal law, rule or regulation.

G. **Audits**

1. Single Audit

   Provide, consistent with the regulations set forth in the Single Audit Act Amendments of 1996, P.L. 104-156, and "Title 2 Code of Federal Regulations (CFR) Part 200, Subpart F Audit Section .320 of the Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations," a copy of the Grantee's annual Single Audit reporting package, including the Corrective Action Plan, and management letter (if one is issued) with a response to the Department.

   The Grantee must assure that the Schedule of Expenditures of Federal Awards includes expenditures for all federally-funded grants.

2. Other Audits

   The Department or federal agencies, may also conduct or arrange for "agreed upon procedures" or additional audits to meet their needs.

with laws, regulations, and the provisions of contracts, and that performance goals are achieved. The subrecipient monitoring plan should include a risk-based assessment to determine the level of oversight, and monitoring activities such as reviewing financial and performance reports, performing site visits, and maintaining regular contact with subrecipients.

The Grantee must establish requirements to ensure compliance by **for-profit subrecipients** as required by Title 2 CFR Section 200.501(h), as applicable

The Grantee must ensure that transactions with **contractors** comply with laws, regulations and provisions of contracts or grant agreements in compliance with Title 2 CFR Section 200.501(h), as applicable

I. **Notification of Modifications**

Provide timely notification to the Department, in writing, of any action by the Grantee, its governing board or any other funding source which would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

J. **Software Compliance**

The Grantee must ensure software compliance and compatibility with the Department's data systems for services provided under this agreement including, but not limited to: stored data, databases, and interfaces for the production of work products and reports. All required data under this agreement shall be provided in an accurate and timely manner without interruption, failure or errors due to the inaccuracy of the Grantee's business operations for processing date/time data. All information systems, electronic or hard copy that contain State or Federal data must be protected from unauthorized access.

K. **Human Subjects**

The Grantee will comply with Protection of Human Subjects Act, 45 CFR, Part 46. The Grantee agrees that prior to the initiation of the research, the Grantee will submit institutional Review Board (IRB) application material for all research involving human subjects, which is conducted in programs sponsored by the Department or in programs which receive funding from or through the State of Michigan, to the Department's IRB for review and approval, or the IRB application and approval materials for acceptance of the review of another IRB. All such research must be approved by a federally assured IRB, but the Department's IRB can only accept the review and approval of another institution's IRB under a formally-approved interdepartmental agreement. The manner of the review will be agreed upon between the Department's IRB Chairperson and the Grantee's IRB Chairperson or Executive Officer(s).

L. **Terms**

To abide by the terms of this agreement including all attachments.

ability to fulfill its contractual obligations under the Comprehensive Planning, Budgeting and Contracting Agreement. Grantees designated as "Not Accredited", will retain this designation until the subsequent accreditation cycle.

c. Grantee failure to fulfill the terms and conditions of the Consent Agreement within the prescribed time period will result in the issuance of an Administrative Compliance Order by the Department.

d. Within 60 working days after receipt of an Administrative Compliance Order and proposed compliance period, a local governing entity may petition the Department for an administrative hearing. If the local governing entity does not petition the Department for a hearing within 60 days after receipt of an Administrative Compliance Order, the order and proposed compliance date shall be final. After a hearing, the Department may reaffirm, modify, or revoke the order or modify the time permitted for compliance.

e. If the local governing entity fails to correct a deficiency for which a final order has been issued within the period permitted for compliance, the Department may petition the appropriate circuit court for a writ of mandamus to compel correction.

Q. Medicaid Outreach Activities Reimbursement

The Grantee agrees to report allowable costs and request reimbursement for the Medicaid Outreach activities it provides in accordance with 2 CFR, Part 225 (OMB Circular A-87) and the requirements in Medicaid Bulletin number: MSA 05-29.

The Grantee agrees to submit a Cost Allocation Plan Certification to the Department to bill for the Medicaid Outreach Activities. The Cost Allocation Plan Certification is valid until a change is made to the cost allocation plan or the Department determines it is invalid.

The Grantee will submit quarterly FSRs for the Medicaid Outreach activities and an annual FSR for the Children with Special Health Care Services Medicaid Outreach activities in accordance with the instructions contained in Attachment I.

In accordance with the Medicaid Bulletin, MSA 05-29, the Grantee agrees to target their Medicaid outreach effort toward Department established priorities. For FY 15/16, the Department priorities are: lead testing, outreach and enrollment for the Family Planning waiver, and outreach for pregnant women, mothers and infants for the Maternal and Infant Health Program. The Grantee will submit a report using the MDCH Local Health Department Medicaid Outreach form describing their outreach activities targeting the priorities 30 days after the end of a fiscal year quarter and at the same time as the final

H. Reimbursement

To reimburse local agencies for costs based upon timely, accurately completed Financial Status Reports in accordance with Section IV.

I. Technical Assistance

To make technical assistance available to the Grantee for the implementation of this agreement.

J. Health Insurance Portability and Accountability

The Department assures that it will be in compliance with the Health Insurance Portability and Accountability Act.

K. Accreditation

The Department agrees to adhere to the accreditation requirements including the process for "Not Accredited" Grantees. The process includes developing and monitoring consent agreements, issuing and monitoring administrative compliance orders, participating in administrative hearings and petitioning appropriate circuit courts.

L. Medicaid Outreach Activities Reimbursement

The Department agrees to reimburse the Grantee for all allowable Medicaid Outreach activities that meet the standards of the Medicaid Bulletin: MSA 05-29 including the cost allocation plan certification and that are billed in accordance with the requirements in Attachment I.

In accordance with the Medicaid Bulletin, MSA 05-29, the Department will identify each fiscal year the Medicaid Outreach priorities and establish a reporting requirement for the Grantee.

III. Assurances

The following assurances are hereby given to the Department:

A. Compliance with Applicable Laws

The Grantee will comply with applicable federal and state laws, guidelines, rules and regulations in carrying out the terms of this agreement. The Grantee will also comply with all applicable general administrative requirements such as OMB Circulars covering cost principles, grant/agreement principles, and audits in carrying out the terms of this agreement.

B. Anti-Lobbying Act

The Grantee will comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq, and Section 503 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies section of the FY 1997 Omnibus Consolidated Appropriations Act (Public Law 104-208). Further, the Grantee shall require that the language of this assurance be included in the award documents of all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

under which application for Federal assistance is being made; and,

i. the requirements of any other nondiscrimination statute(s) which may apply to the application.

3. Additionally, assurance is given to the Department that proactive efforts will be made to identify and encourage the participation of minority owned and women owned businesses, and businesses owned by persons with disabilities in contract solicitations. The Grantee shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority owned and women owned businesses and businesses owned by persons with disabilities in subcontracting; and (2) making discrimination a material breach of contract.

D. Debarment and Suspension

Assurance is hereby given to the Department that the Grantee will comply with Federal Regulation, 2 CFR part 180 and certifies to the best of its knowledge and belief that the Grantee's local health department or an official of the Grantee's local health department and the Grantee's subcontractors:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or Grantee;
2. Have not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
3. Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in section 2, and;
4. Have not within a three-year period preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.

E. Federal Requirement: Pro-Children Act

1. Assurance is hereby given to the Department that the Grantee will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either

threshold.

H. **Home Health Services**

If the Grantee provides Home Health Services (as defined in Medicare Part B), the following requirements apply:

1. The Grantee shall not use State ELPHS or categorical grant funds provided under this agreement to unfairly compete for home health services available from private providers of the same type of services in the Grantee's service area.
2. For purposes of this agreement, the term "unfair competition" shall be defined as offering of home health services at fees substantially less than those generally charged by private providers of the same type of services in the Grantee's area, except as allowed under Medicare customary charge regulations involving sliding fee scale discounts for low-income clients based upon their ability to pay.
3. If the Department finds that the Grantee is not in compliance with its assurance not to use state ELPHS and categorical grant funds to unfairly compete, the Department shall follow the procedure required for failure by local health departments to adequately provide required services set forth in Sections 2497 and 2498 of 1978 PA 368 as amended (Public Health Code), MCL 333.2497 and 2498, MSA 14.15 (2497) and (2498).

I. **Subcontracts**

Assure for any subcontracted service, activity or product:

1. That a written subcontract is executed by all affected parties prior to the initiation of any new subcontract activity. Exceptions to this policy may be granted by the Department upon written request.
2. That any executed subcontract shall require the subcontractor to comply with all applicable terms and conditions of this agreement. In the event of a conflict between this agreement and the provisions of the subcontract, the provisions of this agreement shall prevail. A conflict between this agreement and a subcontract, however, shall not be deemed to exist where the subcontract:
   a. Contains additional non-conflicting provisions not set forth in this agreement; or
   b. Restates provisions of this agreement to afford the Grantee the same or substantially the same rights and privileges as the Department; or
   c. Requires the subcontractor to perform duties and/or services in less time than that afforded the Grantee in this agreement.
3. That the subcontract does not affect the Grantee's accountability to the Department for the subcontracted activity.
4. That any billing or request for reimbursement for subcontract costs is

purchases are maintained for a minimum of three years after the end of the agreement period.

K. Health Insurance Portability and Accountability Act

To the extent that this act is pertinent to the services that the Grantee provides to the Department under this agreement, the Grantee assures that it is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements including the following:

1. The Grantee must not share any protected health data and information provided by the Department that falls within HIPAA requirements except as permitted or required by applicable law; or to a subcontractor as appropriate under this agreement.
2. The Grantee will ensure that any subcontractor will have the same obligations as the Grantee not to share any protected health data and information from the Department that falls under HIPAA requirements in the terms and conditions of the subcontract.
3. The Grantee must only use the protected health data and information for the purposes of this agreement.
4. The Grantee must have written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements. The policies and procedures must meet all applicable federal and state requirements including the HIPAA regulations. These policies and procedures must include restricting access to the protected health data and information by the Grantee's employees.
5. The Grantee must have a policy and procedure to immediately report to the Department any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements of which the Grantee becomes aware. The Grantee will work with the Department to mitigate the breach, and will provide assurances to the Department of corrective actions to prevent further unauthorized uses or disclosures.
6. Failure to comply with any of these contractual requirements may result in the termination of this agreement in accordance with Part II, Section V. Agreement Termination.
7. In accordance with HIPAA requirements, the Grantee is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information by the Grantee received from the Department or any other source.
8. The Grantee will enter into a business associate agreement should the Department determine such an agreement is required under HIPAA.

are due 1/30, 4/30, and 7/30.

FSR's must report total actual program expenditures regardless of the source of funds. The Department will reimburse the Grantee for expenditures in accordance with the terms and conditions of this agreement. Failure to comply with the reporting due dates will result in the deferral of the Grantee's monthly prepayment.

E. Reimbursement Method

The Grantee will be reimbursed in accordance with the reimbursement methods for applicable program elements described as follows:

1. Performance Reimbursement - A reimbursement method by which Grantees are reimbursed based upon the understanding that a certain level of performance (measured by outputs) must be met in order to receive full reimbursement of costs (net of program income and other earmarked sources) up to the contracted amount of State funds. Any local funds used to support program elements operated under such provisions of this agreement may be transferred by the Grantee within, among, to or from the affected elements without Department approval, subject to applicable provisions of Sections 3.B. and 3.C.3 of Part I and Section XIV of Part II. If Grantee's performance falls short of the expectation by a factor greater than the allowed minimum performance percentage, the State maximum allocation will be reduced equivalent to actual performance in relation to the minimum performance.

2. Staffing Grant Reimbursement - A reimbursement method by which Grantees are reimbursed based upon the understanding that State dollars will be paid up to total costs in relation to the State's share of the total costs and up to the total State allocation as agreed to in the approved budget. This reimbursement approach is not directly dependent upon whether a specified level of performance is met by the local health department. Department funding under this reimbursement method is allocable as a source before any local funding requirement unless a specific local match condition exists.

3. Fixed Unit Rate Reimbursement - A reimbursement method by which Grantee are reimbursed a specific amount for each output actually delivered and reported.

4. Essential Local Public Health Services (ELPHS) - A reimbursement method by which Grantees are reimbursed a share of reasonable and allowable costs incurred for required services, as noted in the current Appropriations Act.

F. Reimbursement Mechanism

All Grantees must sign up through the on-line vendor registration process to receive all State of Michigan payments as Electronic Funds Transfers

Grantee or if the Grantee owes funds to the Department. If funds are owed to the Grantee, payment will be processed. However, if the Grantee underestimated their year-end obligations in the Obligation Report as compared to the final FSR and the total reimbursement requested does not exceed the agreement amount that is due to the Grantee, the Department will make every effort to process full reimbursement to the Grantee per the final FSR. Final payment may be delayed pending final disposition of the Department's year-end obligations.

If funds are owed to the Department, it will generally not be necessary for Grantee to send in a payment. Instead the Department will make the necessary entries to offset other payments and as a result the Grantee will receive a net monthly prepayment. When this does occur, clarifying documentation will be provided to the Grantee by the Department's Accounting Division.

J. Penalties for Reporting Noncompliance

For failure to submit the final total Grantee FSR report by December 15, through MI E-Grants after the agreement period end date, the Grantee may be penalized with a one-time reduction in their current ELPHS allocation for noncompliance with the fiscal year-end reporting deadlines. Any penalty funds will be reallocated to other Comprehensive Grantees (local health departments). Reductions will be one-time only and will not carryforward to the next fiscal year as an ongoing reduction to a Grantee's ELPHS allocation. Penalties will be assessed based upon the submitted date in MI E-Grants:

ELPHS Penalties for Noncompliance with Reporting Requirements:

1. 1% - 1 day to 30 days late;
2. 2% - 31 days to 60 days late;
3. 3% - over 60 days late with a maximum of 3% reduction in the Grantee's ELPHS allocation.

K. Indirect Costs and Cost Allocations/Distribution Plans

The Grantee is allowed to use approved federal indirect rate, 10% de minimis indirect rate and/or cost allocation/distribution plans in their budget calculations.

1. Costs must be consistently charged as indirect, direct or cost allocated, but may not be double charged or inconsistently charged.
2. If the Grantee does not have an existing approved federal indirect rate, they may use a 10% de minimis rate in accordance with Title 2 Code of Federal Regulations (CFR) Part 200 to recover their indirect costs.
3. Grantees using the cost allocation/distribution method must develop certified plan in accordance with the requirements described in Title 2 CFR, Part 200 which includes detailed budget narratives and is retained by the Grantee and subject to Department review.
4. There must be a documented, well-defined rationale and audit trail for any cost distribution or allocation based upon Title 2 CFR, Part 200 Cost

C. Amendments to this agreement shall be made as follows:

1. Any change proposed by the Grantee which would affect the State funding of any element funded in whole or in part by funds provided by the Department, subject to Part I, Section 3.C, of the agreement, must be submitted in writing to the Department immediately upon determining the need for such change. The proposed change may be implemented upon receipt of written notification from the Department.

   Within thirty (30) days after receipt of the proposed change, the Department shall advise the Grantee in writing of its determination. Subsequently the Department will initiate any necessary formal amendment to the agreement for execution by all parties to the agreement.

   Any changes proposed by the Department must be agreed to in writing by the Grantee and upon such written agreement, the Department shall initiate any necessary formal amendment as above.

2. Other amendments of a routine nature including applicable changes in budget categories, modified indirect rates, and similar conditions which do not modify the agreement scope, amount of funding to be provided by the Department or, the total amount of the budget may be submitted by the Grantee at any time prior to June 2nd. The Department will provide a written response within thirty (30) calendar days.

   All amendments must be submitted to the Department by June 15 through MI E-Grants to assure the amendment can be executed prior to the end of the agreement period.

IX. Liability

A. All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities, such as direct service delivery, to be carried out by the Grantee in the performance of this agreement shall be the responsibility of the Grantee, and not the responsibility of the Department, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of the Grantee, any subcontractor, anyone directly or indirectly employed by the Grantee, provided that nothing herein shall be construed as a waiver of any governmental immunity that has been provided to the Grantee or its employees by statute or court decisions.

B. All liability to third parties, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities, such as the provision of policy and procedural direction, to be carried out by the Department in the performance of this agreement shall be the responsibility of the Department, and not the responsibility of the Grantee, if the liability, loss, or damage is caused by, or

B. The funding provided through the Department for this agreement shall not exceed the amount shown for each federal and state categorical program element except as adjusted by amendment. The Grantee must advise the Department in writing by May 1, if the amount of Department funding may not be used in its entirety or appears to be insufficient for any program element. ELPHS transfer requests between MDCH, MDARD and MDEQ must also be requested in writing by May 1. All ELPHS required services must be maintained throughout the entire period of the agreement.

C. The Department may periodically redistribute funds between agencies during the agreement period in order to ensure that funds are expended to meet the varying needs for services. Such redistributions will be based upon projections obtained in consultation with the Grantee. Any redistributions will be effected through the established amendment process.

AA Attachments

A1 Attachment I - Instructions for the Annual Budget

Attachment I - Instructions for the Annual Budget

A2 Attachment III - Program Specific Assurances and Requirements

Attachment III - Program Specific Assurances and Requirements

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
ATTACHMENT IV - Comprehensive Agreement - 2016
CONTRACT MANAGEMENT SECTION
City of Detroit Department of Health and Wellness

Program Element/Funding Source (a)	MDCH Source	Fed/St	Funding Amount	Reimbursement Method (b)	Performance Target Output Measurement	Total (c) Perform Expect	State (d) Funded Target Perform	State Funded Minimum Performance Number (e)	State Funded Minimum Percent	Contractor / Subrecepient (f)
WIC Resident Services	Reg. Alloc.	F	5,050,059	Performance (8)	# Average Monthly Participation	N/A	31774	97	30820	Subrecepient

TOTAL MDCH FUNDING **8,561,448**

***SPECIFIC OUTPUT PERFORMANCE MEASURES WILL BE INCORPORATED VIA AMENDMENT**

Attachment IV Notes

Attachment IV Notes

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	16,325.00	0.00	16,325.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	163,254.00	0.00	0.00	163,254.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	163,254.00	16,325.00	0.00	179,579.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Body Art Fixed Fee			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	0.00	0.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	0.00	0.00
2	Other Costs Distributions	9,500.00	9,500.00
Total Indirect Costs		9,500.00	9,500.00
TOTAL INDIRECT EXPENSES		9,500.00	9,500.00
TOTAL EXPENDITURES		**9,500.00**	**9,500.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
2	**Other Costs Distributions**					
	Cost Distributions for Fees-Tattoo Palor	0.0000	0.000	0.000		9,500.00
Total Indirect Costs						9,500.00
TOTAL INDIRECT EXPENSES						9,500.00
TOTAL EXPENDITURES						**9,500.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	53,750.00	0.00	0.00	53,750.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	53,750.00	0.00	0.00	53,750.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Childhood Lead Poisoning Prevention			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	105,635.00	105,635.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
Total Program Expenses		105,635.00	105,635.00
TOTAL DIRECT EXPENSES		105,635.00	105,635.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	3,600.00	3,600.00
2	Other Costs Distributions	10,765.00	10,765.00
Total Indirect Costs		14,365.00	14,365.00
TOTAL INDIRECT EXPENSES		14,365.00	14,365.00
TOTAL EXPENDITURES		**120,000.00**	**120,000.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
	Subcontracting Agency-SOUTHEATERN MICHIG	0.0000	0.000	0.000		105,635.00
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
Total Program Expenses						105,635.00
TOTAL DIRECT EXPENSES						105,635.00
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
	Cost Allocation Plan	0.0000	3.000	120000.000		3,600.00
2	**Other Costs Distributions**					
	Health Adm Distribution	0.0000	0.000	0.000		10,765.00
Total Indirect Costs						14,365.00
TOTAL INDIRECT EXPENSES						14,365.00
TOTAL EXPENDITURES						**120,000.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	18,460.00	0.00	18,460.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	184,556.00	0.00	0.00	184,556.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	184,556.00	18,460.00	0.00	203,016.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Fetal Infant Mortality Review (FIMR) Case Abstraction			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	2,619.00	2,619.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
Total Program Expenses		2,619.00	2,619.00
TOTAL DIRECT EXPENSES		2,619.00	2,619.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	81.00	81.00
2	Other Costs Distributions	0.00	0.00
Total Indirect Costs		81.00	81.00
TOTAL INDIRECT EXPENSES		81.00	81.00
TOTAL EXPENDITURES		**2,700.00**	**2,700.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
	Subcontracting Agency-SOUTHEASTERN MICHI	0.0000	0.000	0.000		2,619.00
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
Total Program Expenses						2,619.00
TOTAL DIRECT EXPENSES						2,619.00
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
	Cost Allocation Plan	0.0000	3.000	2700.000		81.00
2	**Other Costs Distributions**					
Total Indirect Costs						81.00
TOTAL INDIRECT EXPENSES						81.00
TOTAL EXPENDITURES						**2,700.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	546,483.00	0.00	0.00	546,483.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	546,483.00	0.00	0.00	546,483.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Hearing ELPHS			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	265,197.00	265,197.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
Total Program Expenses		265,197.00	265,197.00
TOTAL DIRECT EXPENSES		265,197.00	265,197.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	9,038.00	9,038.00
2	Other Costs Distributions	27,026.00	27,026.00
Total Indirect Costs		36,064.00	36,064.00
TOTAL INDIRECT EXPENSES		36,064.00	36,064.00
TOTAL EXPENDITURES		**301,261.00**	**301,261.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
	Subcontracting Agency-SOUTHEASTERN MICHI	0.0000	0.000	0.000		265,197.00
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
Total Program Expenses						265,197.00
TOTAL DIRECT EXPENSES						265,197.00
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
	Cost Allocation Plan	0.0000	3.000	301261.000		9,038.00
2	**Other Costs Distributions**					
	Health Adm Distribution	0.0000	0.000	0.000		27,026.00
Total Indirect Costs						36,064.00
TOTAL INDIRECT EXPENSES						36,064.00
TOTAL EXPENDITURES						**301,261.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	50,000.00	0.00	0.00	50,000.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	50,000.00	0.00	0.00	50,000.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Immunization Action Plan (IAP)			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	297,176.00	297,176.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
Total Program Expenses		297,176.00	297,176.00
TOTAL DIRECT EXPENSES		297,176.00	297,176.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	10,128.00	10,128.00
2	Other Costs Distributions	30,283.00	30,283.00
Total Indirect Costs		40,411.00	40,411.00
TOTAL INDIRECT EXPENSES		40,411.00	40,411.00
TOTAL EXPENDITURES		**337,587.00**	**337,587.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
	Subcontracting Agency-SOUTHEASTERN MICHI	0.0000	0.000	0.000		297,176.00
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
Total Program Expenses						297,176.00
TOTAL DIRECT EXPENSES						297,176.00
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
	Cost Allocation Plan	0.0000	3.000	337587.000		10,128.00
2	**Other Costs Distributions**					
	Health Adm Distribution	0.0000	0.000	0.000		30,283.00
Total Indirect Costs						40,411.00
TOTAL INDIRECT EXPENSES						40,411.00
TOTAL EXPENDITURES						**337,587.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	20,000.00	0.00	0.00	20,000.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	20,000.00	0.00	0.00	20,000.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Immunization ELPHS			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	1,056,353.00	1,056,353.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
Total Program Expenses		1,056,353.00	1,056,353.00
TOTAL DIRECT EXPENSES		1,056,353.00	1,056,353.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	36,000.00	36,000.00
2	Other Costs Distributions	107,647.00	107,647.00
Total Indirect Costs		143,647.00	143,647.00
TOTAL INDIRECT EXPENSES		143,647.00	143,647.00
TOTAL EXPENDITURES		**1,200,000.00**	**1,200,000.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
	Subcontracting Agency-SOUTHEASTERN MICHI	0.0000	0.000	0.000		1,056,353.00
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
Total Program Expenses						1,056,353.00
TOTAL DIRECT EXPENSES						1,056,353.00
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
	Cost Allocation Plan	0.0000	3.000	1200000.000		36,000.00
2	**Other Costs Distributions**					
	Health Adm Distribution	0.0000	0.000	0.000		107,647.00
Total Indirect Costs						143,647.00
TOTAL INDIRECT EXPENSES						143,647.00
TOTAL EXPENDITURES						**1,200,000.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	45,000.00	0.00	0.00	45,000.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	45,000.00	0.00	0.00	45,000.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Public Health Emergency Preparedness (PHEP) Ebola Virus Disease (EVD) Phase II			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	45,456.00	45,456.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
Total Program Expenses		45,456.00	45,456.00
TOTAL DIRECT EXPENSES		45,456.00	45,456.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	1,549.00	1,549.00
2	Other Costs Distributions	4,632.00	4,632.00
Total Indirect Costs		6,181.00	6,181.00
TOTAL INDIRECT EXPENSES		6,181.00	6,181.00
TOTAL EXPENDITURES		**51,637.00**	**51,637.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
	Subcontracting Agency-SOUTHEASTERN MICHI	0.0000	0.000	0.000		45,456.00
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
Total Program Expenses						45,456.00
TOTAL DIRECT EXPENSES						45,456.00
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
	Cost Allocation Plan	0.0000	3.000	51637.000		1,549.00
2	**Other Costs Distributions**					
	Health Adm Distribution	0.0000	0.000	0.000		4,632.00
Total Indirect Costs						6,181.00
TOTAL INDIRECT EXPENSES						6,181.00
TOTAL EXPENDITURES						**51,637.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	301,261.00	0.00	0.00	301,261.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	301,261.00	0.00	0.00	301,261.00

1 Program Budget Summary

PROGRAM / PROJECT Comprehensive Agreement - 2016 / WIC Breastfeeding			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	0.00	0.00
2	Fringe Benefits	0.00	0.00
3	Cap. Exp. for Equip & Fac.	0.00	0.00
4	Contractual	117,871.00	117,871.00
5	Supplies and Materials	0.00	0.00
6	Travel	0.00	0.00
7	Communication	0.00	0.00
8	County-City Central Services	0.00	0.00
9	Space Costs	0.00	0.00
10	All Others (ADP, Con. Employees, Misc.)	0.00	0.00
Total Program Expenses		117,871.00	117,871.00
TOTAL DIRECT EXPENSES		117,871.00	117,871.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	4,017.00	4,017.00
2	Other Costs Distributions	12,012.00	12,012.00
Total Indirect Costs		16,029.00	16,029.00
TOTAL INDIRECT EXPENSES		16,029.00	16,029.00
TOTAL EXPENDITURES		**133,900.00**	**133,900.00**

3 Program Budget - Cost Detail

	Line Item	Qty	Rate	Units	UOM	Total
DIRECT EXPENSES						
Program Expenses						
1	**Salary & Wages**					
2	**Fringe Benefits**					
3	**Cap. Exp. for Equip & Fac.**					
4	**Contractual**					
	Subcontracting Agency-SOUTHEASTERN MICHI	0.0000	0.000	0.000		117,871.00
5	**Supplies and Materials**					
6	**Travel**					
7	**Communication**					
8	**County-City Central Services**					
9	**Space Costs**					
10	**All Others (ADP, Con. Employees, Misc.)**					
Total Program Expenses						117,871.00
TOTAL DIRECT EXPENSES						117,871.00
INDIRECT EXPENSES						
Indirect Costs						
1	**Indirect Costs**					
	Cost Allocation Plan	0.0000	3.000	133900.000		4,017.00
2	**Other Costs Distributions**					
	Health Adm Distribution	0.0000	0.000	0.000		12,012.00
Total Indirect Costs						16,029.00
TOTAL INDIRECT EXPENSES						16,029.00
TOTAL EXPENDITURES						**133,900.00**

2 Program Budget - Source of Funds

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	**Source of Funds**				
	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
	Federal Cost Based Reimbursement	0.00	0.00	0.00	0.00
	Federally Provided Vaccines	0.00	0.00	0.00	0.00
	Federal Medicaid Outreach	0.00	0.00	0.00	0.00
	Required Match - Local	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Local Non-ELPHS	0.00	0.00	0.00	0.00
	Other Non-ELPHS	0.00	0.00	0.00	0.00
	MDHHS Non Comprehensive	0.00	0.00	0.00	0.00
	MDHHS Comprehensive	5,050,059.00	0.00	0.00	5,050,059.00
	ELPHS - MDHHS Hearing	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Vision	0.00	0.00	0.00	0.00
	ELPHS - MDHHS Other	0.00	0.00	0.00	0.00
	ELPHS - Food	0.00	0.00	0.00	0.00
	ELPHS - Private / Type III Water Supply	0.00	0.00	0.00	0.00
	ELPHS - On-Site Wastewater Treatment	0.00	0.00	0.00	0.00
	MCH Funding	0.00	0.00	0.00	0.00
	Local Funds - Other	0.00	0.00	0.00	0.00
	Inkind Match	0.00	0.00	0.00	0.00
	MDHHS Fixed Unit Rate				
	Totals	5,050,059.00	0.00	0.00	5,050,059.00

Summary of Budget

PROGRAM / PROJECT Comprehensive Agreement - 2016 / Comprehensive Agreement - 2016			**DATE PREPARED** 10/1/2015	
CONTRACTOR NAME City of Detroit Department of Health and Wellness			**BUDGET PERIOD** From : 10/1/2015 To : 9/30/2016	
MAILING ADDRESS (Number and Street) City Treasurer 1151 Taylor Ste 333-C			**BUDGET AGREEMENT** ☑ Original ☐ Amendment	**AMENDMENT #** 0
CITY Detroit	**STATE** MI	**ZIP CODE** 48202-1732	**FEDERAL ID NUMBER** 38-6004606	

	Category	Amount	Total
DIRECT EXPENSES			
Program Expenses			
1	Salary & Wages	31,427.00	31,427.00
2	Contractual	8,009,432.00	8,009,432.00
3	Space Costs	3,358.00	3,358.00
Total Program Expenses		8,044,217.00	8,044,217.00
TOTAL DIRECT EXPENSES		8,044,217.00	8,044,217.00
INDIRECT EXPENSES			
Indirect Costs			
1	Indirect Costs	256,845.00	256,845.00
2	Other Costs Distributions	304,671.00	304,671.00
Total Indirect Costs		561,516.00	561,516.00
TOTAL INDIRECT EXPENSES		561,516.00	561,516.00
TOTAL EXPENDITURES		**8,605,733.00**	**8,605,733.00**

SOURCE OF FUNDS

	Category	Amount	Cash	Inkind	Total
1	Fees and Collections - 1st and 2nd Party	0.00	0.00	0.00	0.00
2	Fees and Collections - 3rd Party	0.00	0.00	0.00	0.00
3	Federal or State (Non MDCH)	0.00	0.00	0.00	0.00
4	Federal Cost Based	0.00	0.00	0.00	0.00

Attachment 11

FULLY EXECUTED

Agreement Between
SOUTHEASTERN MICHIGAN HEALTH ASSOCIATION
Hereinafter referred to as "*SEMHA*"
and WAYNE STATE UNIVERSITY (WSU)
(Federal EIN# 38-6028429)
Hereinafter referred to as "Agency"
CONTRACT
For the
For the period September 1, 2015 and September 30, 2015

Purpose

The purpose of this agreement is to establish the responsibilities of the *Agency* and *SEMHA* in the provision of services as set forth in Attachment A: Scope of Services. The City of Detroit hereinafter referred to as the *Grantor*. These funds are identified in the City of Detroit contract with the Michigan Department of Human Services.

Program Budget and Agreement Amount

SEMHA under the terms of this agreement will provide funding not to exceed **$58,368.00**. This will be supported by Program Budgets that have been approved by *SEMHA* and are hereby made part of this agreement as Attachment B: Budget.

This agreement is conditionally approved subject to and contingent upon the availability of funds from the Grantor.

Agreement Period

The *Agency* shall commence performance of this agreement and the rendering of the services required herein on **September 1, 2015** The services shall be completed on or before **September 30, 2015.**

Agency Representation and Warranties

The *Agency* is authorized to do business under the laws of the State of Michigan and is duly qualified to perform the Services as set forth in this agreement. The execution of this agreement is within the *Agency*'s authorized powers and is not a contravention of federal, state or local law.

3. Pro-Children Act – The *Agency* shall comply with Public Law 103-277, also known as the Pro-Children Act of 1994 (ACT), which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through state or local governments, by Federal grant, contract, loan or loan guarantee. The law also applies to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service contractors whose sole source of applicable Federal funds in Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The *Agency* also assures that this language will be included in any subcontracts which contain provision for children's services.

4. Hatch Act and Intergovernmental Personnel Act – The *Agency* shall comply with the Hatch Act (5 ZU.S.C. 1501 – 1508) and Intergovernmental Personnel act of 1970, as amended by Title VI of Civil Service Reform Act (Public Law 95-454 Section 4728). Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally-assisted programs.

5. Non- Discrimination – The *Agency* assures that, in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. 794), Title IX of the Educational Amendment of 1972 as amended, (42 U.S.C.6101 et seq.), the Regulations of the U.S. Department of Health and Human Services (45 CFR Parts 80, 84, 86, & 91), the Michigan Handicappers' Civil Rights Act (1976, PA 220), and the Michigan Civil Rights Act (1976, PA 453), no individual shall, on the ground of race, creed, age, color, national origin or ancestry, religion, sex, marital status or handicap be excluded from participation, denied any benefits of, or be otherwise subjected to discrimination under any program or activity provided by the *Agency*.

6. Debarment And Suspension – Assurance is hereby given that the *Agency* will comply with Federal regulation 45 CFR Part 76 and certify to the best of its knowledge and belief that it and its Subcontractors:

   a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or *Agency*;

D. Maintain adequate program and financial records and files including source documentation to support program activities and all expenditures made under the terms of this agreement, as required.

E. Provide Financial Status Report (FSR), or equivalent, with back-up detail to *SEMHA*. *SEMHA* will reimburse the *Agency* for actual costs incurred. If the *Agency* is not in compliance because of non-performance, and/or, submission of reports the *Agency* may not be reimbursed. Further, program non-compliance can delay reimbursement until the program compliance issues and any related financial consequences are resolved.

F. The *Agency* shall assure that all terms of the agreement will be appropriately adhered to and maintain full and complete records reflecting all operations related to this contract. The records shall be kept in accordance with generally accepted accounting principles and maintained for a minimum of three (3) years from the date of termination, the date of submission of the final expenditure report or until litigation or audit findings have been resolved. The *Agency* will maintain records to adequately reflect performance under the contract, and agree to preserve and make available to such records, upon request, for a period of three (3) years from the date the Services were rendered by the Agency. *SEMHA* has the right to monitor all contract-related activities of the Agency and its sub-contractors, including, but not limited to, the right to observe all contract personnel in performance of contract-related work, to make, at any time, site inspections, and to bring experts and consultants on site to evaluate work in progress and completed work.

G. Upon two (2) business days' prior written notice, permit *SEMHA*, authorized representatives of *SEMHA*. Grantor, or any of their duly authorized representatives, to review all records, files and documentation related to this agreement. *SEMHA*, or its designated representatives, shall have the right to audit, examine and make copies of all data, billing records, invoices, payments, documents, information, procedures and records of any type and form, and test hardware in the possession or control of the Agency that relate to or concern the services or Agency 's relationship with the *SEMHA*. Agency shall grant full access to the Agency's facilities and afford all assistance reasonably necessary so that *SEMHA* and its representatives may complete any audit. *SEMHA* will not be held responsible for time or miscellaneous costs incurred by the Agency in association with any audit, including the costs associated with providing audit logs, systems access, or space.

H. Utilize all report forms, reporting formats and approved reporting systems required by *SEMHA*, or the *Grantor*. The Agency shall inform *SEMHA* of any and all budget surpluses that may arise in the performance of this contract arising from unfilled staffing positions or other contractual delays.

resolve said dispute, however, the *Grantor*'s final determination shall govern any such dispute.

Any audit exceptions for disallowed costs shall be paid by the *Agency* to *SEMHA* within thirty (30) days of notification or, if there is an appeal, the *Agency* shall pay any remaining audit exception within thirty (30) days after conclusion of the appeal process. If the *Agency* fails to repay such audit exceptions as described above, they may be set-off by *SEMHA* against any funds due and owing the *Agency* which are being held by *SEMHA*, provided, however, that the *Agency* shall remain liable for any remaining deficiencies.

The *Agency* must also assure that each of its subcontractors comply with the above audit requirements, as applicable, and provide for other sub-recipient Monitoring Procedures, as deemed necessary.

A copy of the Audit reporting package or financial audit should be forwarded to:

SEMHA
Attention: Contract/Monitoring Manager
200 Fisher Building
3011 West Grand Boulevard
Detroit, Michigan 48202

M. Agree that any program reports, articles and publications that result from information gathered through use of these funds acknowledge receipt of that support from the *Grantor*, and *SEMHA*. Publication, journal articles, etc., produced under a Department of Health and Human Services (DHHS) grant-supported project must bear an acknowledgement and disclaimer, as appropriate, such as:

This publication (journal article, etc.) was supported by the Health and Human Services through its Grantee, XXXXX. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Human Services, the Grantor, or the Southeastern Michigan Health Association.

Responsibilities – *SEMHA*

SEMHA in accordance with the general purpose and objectives of this agreement will:

A. Provide payment in accordance with this agreement in an amount not to exceed **$58,368.00** based on appropriate reports, records, and documentation maintained and certified as true and correct by the *Agency*.

B. Provide any special report forms and reporting formats required by *SEMHA*, or the *Grantor* for the operation of the program.

g. The *Agency* violates any of the provisions of this Contract, disregards applicable laws, ordinances, permits, licenses, instructions or orders of *SEMHA*; or

h. The performance of the Contract, in the sole judgment of *SEMHA* is substandard, unprofessional, or faulty and not adequate to the demands of the task to be performed; or

i. The *Agency* fails in any of the agreements herein contained; or

j. The *Agency* ceases to conduct business in the normal course; or

2. If *SEMHA* finds an event of default has occurred, *SEMHA* may issue a Notice of Termination for Cause including the grounds for such Termination. Upon receiving a Notice of Termination for Cause, the *Agency* shall have ten (10) calendar days within which to cure such default. If the default is cured within said ten (10) day period, the right of termination for such default shall cease. If the default is not cured to the satisfaction of *SEMHA*, this Contract shall terminate on the thirtieth calendar day after the *Agency*'s receipt of the Notice of Termination for Cause, unless *SEMHA*, in writing, gives the *Agency* additional time to cure the default. If the default is not cured, this Contract shall terminate automatically for cause at the end of the extended cure period.

3. If, after a Notice of Termination for Cause, it is determined by *SEMHA* that the *Agency* was not in default, the rights and obligations of the parties shall be the same as if the Notice of Termination had been issued pursuant to termination for the convenience of *SEMHA*. Alternatively, in *SEMHA*'s discretion, this Contract may be reinstated, at the sole election of *SEMHA*.

4. The *Agency* and SEMHA shall be mutually liable to *the other* for any damages it sustains by virtue of the *other's* breach of this Contract, or any reasonable costs *SEMHA* or the Agency might incur in enforcing or attempting to enforce this Contract. To the extent allowable by law, such costs shall include reasonable fees and expenses for attorneys, expert witnesses and other consultants.

5. *SEMHA*'s and the Agency's remedies outlined in this contract shall be in addition to any and all other legal or equitable remedies permissible.

C. *SEMHA* shall have the right to terminate this Contract at any time at its convenience by giving the *Agency* thirty (30) business days written Notice of Termination for Convenience in the manner specified in this contract. As of the effective date of the termination, *SEMHA* will be obligated to pay the *Agency* the following: (1) reimbursement of costs and expenses actually incurred prior to the date of termination for items which are provided in Attachment A; (2) the fees for Services performed but not

and/or other parties with which the *Agency* has incurred financial obligations pursuant to the contract; and

H. After termination of the contract, each party shall have the duty to assist the other party in the orderly termination of this contract and the transfer of all aspects hereof, tangible or intangible, as may be necessary for the orderly, non-disrupted business continuance of each party. Both parties shall cooperate in arranging an orderly transfer of clients into other programs.

Amendments

Any changes to this agreement will be valid only if made in writing and accepted by all parties to this agreement.

Liability

The *Agency* agrees to hold *SEMHA* harmless against any and all liabilities, obligations, damages, penalties, claims, costs, charges, losses and expenses (including without limitation, fees and expenses for attorneys, expert witnesses and other consultants) which may be imposed upon, incurred by or asserted against *SEMHA*, its employees, officers, or agents by reason of any of the following occurring during the term of this contract:

Any negligent or tortuous act, error, or omission to the extent attributable to the *Agency* now existing or hereafter created;

Any failure by the *Agency* to perform its obligations either implied or expressed under this contract.

SEMHA agrees to hold *the Agency* harmless against any and all liabilities, obligations, damages, penalties, claims, costs, charges, losses and expenses (including without limitation, fees and expenses for attorneys, expert witnesses and other consultants) which may be imposed upon, incurred by or asserted against the *Agency*, its employees, officers, or agents by reason of any of the following occurring during the term of this contract:

Any negligent or tortuous act, error, or omission to the extent attributable to the *SEMHA* and the SEM Beacon Program now existing or hereafter created;

Any failure by the *SEMHA* and the SEM Beacon Program to perform its obligations either implied or expressed under this contract.

Agency's Liability Insurance

The Agency shall purchase and maintain such insurance as will protect them from claims set forth below which may arise out of or result from the Agency's operations under the contract (purchase order), whether such operations be by the contractor or by any subcontractor or by

Each subcontract entered into shall provide that the provision of this Contract shall apply to the Subcontractor and its associates in all respects. The *Agency* agrees to bind each Subcontractor and each Subcontractor shall agree to be bound by the terms of the Contract insofar as applicable to the Subcontractor's work or services.

No approval by the *Grantor* of any proposed Subcontractor, nor any subcontract, nor anything in the Contract, shall create or be deemed to create any rights in favor of a Subcontractor and against the *Grantee*, nor shall it be deemed or construed to impose upon the *Grantee* any obligation, liability or duty to a Subcontractor, or to create any contractual relation whatsoever between a Subcontractor and the *Grantor*.

Confidentiality

SEMHA, the *Grantor*, and the *Agency* shall assure that services to and information contained in records of persons served under this agreement, or other such recorded information required to be held confidential by federal or state law, rule or regulation, in connection with the provision of services or other activity under this agreement shall be privileged communication, shall be held confidential, and shall not be divulged without the written consent of either the client or a person responsible for the client, except as may be otherwise required.

Non-Solicitation

Neither party will directly solicit any employee(s) of the other party who are associated with the efforts called for under this Subcontract during the course of this Subcontract and for a period of one (1) year thereafter. The forgoing prohibition against solicitation of employees will not apply to the placement of general "help wanted" or similar advertisements in publications of national or regional circulation. In the event this clause is breached, liquidated damages equal to twelve (12) months of the employee's compensation plus any legal expenses involved with the enforcement of this provision will be paid by the party in breach of this article to the non-breaching party.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Any information received by the *Agency* in anticipation of or in the course of performing its responsibilities under this Contract which would constitute protected health information under the Health Insurance Portability and Accountability Act of 1996 (The Act) may be used by the *Agency* only for the purpose of fulfilling its responsibilities under this Contract and only in a manner which is consistent with the provision of age Act and the regulations adopted pursuant thereto. The *Agency affirms* that it will:

1. Not use or further disclose the information other than as permitted or required by the Contractor or as required by law;

2. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by this Contract;

Breach of the terms and conditions of this section shall constitute a material breach of this Contract and shall be governed by the provisions of Default and Termination.

Special Certification

The individual or officer signing this agreement certifies by his or her signature that he or she is authorized to sign this agreement on behalf of the responsible governing board, official or *Agency*.

ATTACHMENT A – Scope of Services

Wayne State University in support of Make Your Date (MYD)

Contractor's Activities:

1. Lead health education efforts concerning prenatal healthcare and preterm birth risk reduction.
    a. Develop and lead MYD Preterm Birth Reduction Classes and Events
    b. Distribute health information and literature to pregnant women and families
2. Recommend that mothers seen at MYD partner clinics receive a comprehensive City of Detroit ("City") Department of Health & Wellness Promotion ("DHWP") Maternal Child Health ("MCH") needs assessment (e.g. screen for WIC eligibility) and make referrals to relevant DHWP MCH programs and other social service agencies
3. Publicize MYD events and health information to women at-risk of delivering preterm.
    a. Distribute health information materials in any way, which may include but not be limited to, print, media (TV, Radio), social media (Facebook, Twitter), outreach events
4. Monitor and report data via a Progress Report Form, within 30 days of the end of the completion of services, attached hereto as Attachment C for MYD participants;
    a. Inform DHWP Maternal Child Health staff about the work and progress of MYD through progress reports of activities funded by DHWP, the form of which is attached hereto as Attachment C. MYD will provide reports to DHWP of program activities outlined in the Progress Reports that are funded by DHWP should also include any staffing changes or vacancies that may occur for positions funded whole or in part by DHWP funds.

MDHHS / DHWP / LOCAL MCH WOMEN CONTRACTUAL BUDGET

Attachment B.2

Page 2 of 2

PROGRAM BUDGET - COST DETAIL

- Use WHOLE DOLLARS Only

Program: Make Your Date/WSU	CODE	BUDGET PERIOD From: 09/08/15	To: 09/30/15	Date Prepared: 9/8/2015
Local Agency: Wayne State University (WSU)		ORIGINAL BUDGET A	AMENDED BUDGET	AMENDMENT NUMBER

POSITION DESCRIPTION	% of TIME	Yearly Salary	Allocated Time	
Nurse - Quick, K	0.02	$ 62,000	$ 1,519	$ 146
Nurse - Moss, R	0.02	$ 65,000	$ 1,593	$ 153
Nurse - Hollingworth, K	0.02	$ 65,000	$ 1,593	$ 153
Nurse - Dickson, S	0.02	$ 65,975	$ 1,594	$ 153
Nurse - Nowak, A	0.02	$ 71,000	$ 1,740	$ 167
Nurse - LaGrone, T	0.02	$ 68,500	$ 1,678	$ 161
Nurse - Lane-Beardsley, B	0.02	$ 66,500	$ 1,629	$ 157
Nurse - Nzoma, R	0.02	$ 73,562	$ 1,802	$ 173
Nurse - Walkins, R	0.02	$ 68,500	$ 1,678	$ 161
Labor & Delivery Admin - Walker, T	0.00	$ 34,848	$ 854	$ 82
Program Coordinator - Dwyer, C	0.30	$ 99,775	$ 29,890	$ 2,874
Nurse - Ineson, V	0.03	$ 60,190	$ 6,916	$ 665
Nurse - Mullen, S	0.03	$ 60,560	$ 2,028	$ 195
Nurse - Nikita, L	0.10	$ 84,888	$ 8,809	$ 847
Project Manager- Rodriquez, M	0.30	$ 84,760	$ 25,407	$ 2,443
Finance Manager, Peters, C	0.10	$ 74,707	$ 22,417	$ 2,155
Admin/Secretarial	0.10	$ 44,970	$ 44,970	$ 4,324
Admin/Secretarial	0.10	$ 44,970	$ 44,970	$ 4,324
1. TOTAL SALARIES and WAGES	3.60	$ 1,146,908	$ 201,961	$ 19,335

2. FRINGE BENEFITS: (Specify)		Composite Rate	
FICA	☐ HOSPITA ☐ VISION ☐ WORK COMP	28.60%	
☐ UNEMPLOYMENT INS	☐ LIFE INS ☐ HEARING INS ☐ OTHER		
☐ RETIREMENT	☐ DENTAL INS	2. TOTAL FRINGE BENEFITS	$ 5,143

3. TRAVEL: (Specify if any item exceeds 10% of Total Expenditures)	Amount	
		$ -
		$ -
3. TOTAL TRAVEL		$ -

4. SUPPLIES & MATERIALS: (Specify if any item exceeds 10% of Total Expenditures)	Amount	
Educational - Group Prenatal Care	$ 21,563	
Office Supplies	$ 2,594	
Supplies/Materials - Technological	$ 3,493	
4. TOTAL SUPPLIES & MATERIALS		$ 27,650

5. CONTRACTUAL	Amount	
5. TOTAL CONTRACTUAL		$ -

6. EQUIPMENT: (Specify)	Amount	
	$ -	
	$ -	
6. TOTAL EQUIPMENT		$ -

7. OTHER EXPENSES: (Specify if any item exceeds 10% of Total Expenditures)	Amount	
Participant Social Media Awareness (Paid Posts)	$ 625	
Participant Transportation	$ 4,688	
Participant Incentives:		
Onesies	$ 22.25	
Diaper Bags	$ 22.15	
Tote Bags	$ 5.00	
T-shirts	$ 40.00	
Diapers	$ 187.35	
Wipes	$ 125.00	
Nausea Pops	$ 25.00	
Car Seats	$ 500.00	
7. TOTAL OTHER EXPENSES		$ 8,240

8. TOTAL DIRECT EXPENDITURES: (Sum of Totals 1-7)		$ 58,368
9. INDIRECT COST CALCULATIONS:	Amount	
Rate #1 Base $ x Rate	$ -	$ -
Rate #2 Base $ x Rate	$ -	$ -
9. TOTAL INDIRECT EXPENDITURES		$ -
10. TOTAL ALL EXPENDITURES: (Sum of lines 8-9)		$ 58,368

AUTHORITY: P.A. 368 of 1978

COMPLETION: Is voluntary, but is required as a condition of funding

DCH-0338(E) (Rev. 9-04) (EXCEL) Previous Edition Obsolete

The Department of Community Health is an equal opportunity employer, services and programs provider

Use Additional Sheets as Needed

Nurses work 3 - 12 hours shifts 24 hours a day 7 days a week

Item	Qty.	Cost	Total	Details
DVD's (Prenatal - educational)	15	$ 100.00	$ 1,500.00	Educational and interactive material to provide knowledge on participants pregnancy, labor, breastfeeding, nutrition, etc
Disks (Educational)	15	$ 100.00	$ 1,500.00	
Model Sets (Educational)	15	$ 100.00	$ 1,500.00	
Pregnancy Education Charts	15	$ 100.00	$ 1,500.00	
Motivational Book/Reading Items	15	$ 143.53	$ 2,152.95	
Exercises for a Healthy Pregnancy Booklet (for participants)	1,000	$ 0.79	$ 790.00	
Pregnancy Challenge Game	15	$ 29.60	$ 443.85	
MYD business cards	1,000	$ 0.04	$ 40.00	
MYD brochures	10,000	$ 0.45	$ 4,500.00	Given to all pregnant women in the City of Detroit to provide information on the program and increase participant signup
MYD bracelets	10,000	$ 0.72	$ 7,200.00	
MYD Banners	6	$ 79.99	$ 479.94	
Healthy Mom, Healthy Baby (Pregnancy Basics)	1,000	$ 13.00	$ 13,000.00	Educational books to provide knowledge on how to have a healthy pregnancy
Your Pregnancy and Childbirth: Month to Month (Prego)	1,000	$ 9.00	$ 9,000.00	
What to Expect When You're Expecting (Pregnancy Bk)	1,000	$ 7.77	$ 7,772.00	
MYD handout sets	425	$ 22.10	$ 9,392.50	For participants in preterm birth educational sessions - includes knowledge on all pregnancy related topics
Participant workbooks	425	$ 32.42	$ 13,778.50	
Prenatal education session facilitators guides	100	$ 55.00	$ 5,500.00	For facilitators to conduct the preterm birth educational sessions
ACOG brochures	5,000	$ 0.75	$ 3,750.00	Pregnancy information brochures based on ACOG
Projector Screen (To show educational material)	5	$ 105.79	$ 529.00	To show pregnancy educational material to participants in the lobby of clinic waiting rooms, offsite locations, etc - See attached preterm birth educational session schedule
Projector Lower Platter	5	$ 60.00	$ 300.00	
Projector (To show educational material)	5	$ 310.77	$ 1,553.85	
Total			$ 80,250.49	

Onesies	20	$ 4.65	$ 93.00	Participants are encouraged with incentives to sign-up for the program, attend all of the 9 prenatal care sessions, attend preterm birth educational sessions. All of these items are meant to be sure women have a healthy, full term pregnancy
Diaper Bags	20	$ 4.43	$ 88.60	
Tote Bags	20	$ 1.00	$ 20.00	
T-shirts	20	$ 8.00	$ 160.00	
diapers	20	$ 37.47	$ 749.40	
wipes	20	$ 25.00	$ 500.00	
Nausea pops	20	$ 5.00	$ 100.00	
car seats	20	$ 100.00	$ 2,000.00	
Total			$ 3,711.00	

Printers	3	$ 589.04	$ 1,756.57	Technological items for support staff to be able to work, as well as space to assist in interactive participant activities to increase knowledge with their pregnancies
Laptops	5	$ 1,536.47	$ 7,682.35	
iPad	10	$ 300.00	$ 3,000.00	
iPad Cases	10	$ 49.00	$ 490.00	
Total			$ 13,971.92	

Folders	1000	$ 1.20	$ 1,560.00	
Printer Paper	55	$ 14.99	$ 824.45	
Transcribe for Printers			$ 5,000.00	
Total			$ 10,374.45	

Social Media Awareness (FB & Twitter)	Cost for 2 weeks	$ 2,500.00	
Total		$ 2,500.00	

Participant Transportation	Bus Passes (7 adult rides/7 transfers/$3.50 each)	2,500	$ 3.50	$ 8,750.00	Although health plans are supposed to provide this, participants have expressed still having difficulty obtaining transportation to their prenatal care sessions
	Parking Passes	2,500	$ 4.00	$ 10,000.00	If participants drive, it is difficult for them to be able to afford parking. This is to encourage them to attend their prenatal care sessions
Total				$ 18,750.00	

State Approved	$ 10,335	Salaries
	$ 5,143	Fringes
	$ 33,890	Supplies + Other
		$ 125,586.00
Total State Approved	$ 58,368	
Total Per This Budget	$ 58,368	
Difference	$ 0.04	

Attachment 12

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF AUDIT
P.O. BOX 30815; LANSING, MICHIGAN 48909

NICK LYON
DIRECTOR

June 29, 2018

Joneigh S. Khaldun, MD, MPH, FACEP, Director & Health Officer
City of Detroit Health Department
3245 E. Jefferson, Suite 100
Detroit, MI 48207

Dear Dr. Khaldun:

Enclosed is our final report from the Michigan Department of Health and Human Services (MDHHS) audit of the City of Detroit Local Maternal and Child Health Programs for the period October 1, 2016 through September 30, 2017.

The final report contains the following: Description of Agency; Funding Methodology; Purpose and Objectives; Scope and Methodology; Conclusions, Findings and Recommendations; Adjustment Schedule; Corrective Action Plans; and Comments and Recommendations. The Conclusions, Findings, and Recommendations are organized by audit objective. The Corrective Action Plans and Comments and Recommendations include the agency's paraphrased response to the Preliminary Analysis.

Final reports are posted for public viewing on MDHHS's website at: http://www.michigan.gov/mdhhs/0,5885,7-339-73970_43164-151236--,00.html.

Thank you for the cooperation extended throughout this audit.

Sincerely,

Debra S. Hallenbeck, Director
Audit Division

Attachment

cc: Timothy Lawther, MPH, MA, Deputy Director, City of Detroit Health Department
Joseph Mutebi, MBA, Supervisory Accountant III, City of Detroit Health Department
Pam Myers, Director, Bureau of Audit, MDHHS
Carrie Tarry, MPH, Director, Division of Child & Adolescent Health, MDHHS
Orlando Todd, MBA, Director, Office of Local Health Services, MDHHS
Bryce Wooton, Auditor, Population Health and Community Services Section, MDHHS

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SCOPE AND METHODOLOGY

We examined the Health Department's records and activities for the fiscal period October 1, 2016 to September 30, 2017. Our audit procedures included the following:

- Reviewed the Grant Agreement, Budget, and Program Assurances.
- Reviewed the most recently completed Subrecipient Questionnaire.
- Reviewed the most recent City of Detroit Single Audit Report for any issues relevant to this review.
- Discussed and reviewed monitoring work completed by the MDHHS Division of Child & Adolescent Health staff.
- Evaluated the financial reporting process and tested a sample of transactions for compliance with the established process.
- Reviewed various policies to ensure they meet applicable requirements.
- Evaluated the accuracy and timeliness of Financial Status Report (FSR) submissions.
- Evaluated the payroll allocation process.
- Evaluated compliance monitoring processes and timeliness of corrective action.
- Reviewed the indirect cost allocation methodology for compliance with requirements and supporting documentation.
- Evaluated the fiduciary and grants administration services procurement action for compliance with applicable requirements.

Our review did not include a review of program content or quality of services provided.

CONCLUSIONS, FINDINGS, AND RECOMMENDATIONS

FINANCIAL MANAGEMENT SYSTEM

Objective 1: To assess the effectiveness of the Health Department's financial management system in accordance with applicable requirements.

Conclusion: The Health Department's financial management system was not effective in providing accurate, current, and complete disclosure of the financial results of the Federal award. We identified the following exceptions: inaccurate FSR reporting of contractual costs in every quarterly FSR filed (Finding 1), payroll distributions inappropriately based on budget allocations (Finding 2), inaccurate and incomplete Check Request and Requisition and Approval Forms (Finding 3), and late FSR filings in 94% of the filings (Finding 4).

However, we identified multiple errors in the reconciliation and further needed adjustments. The Health Department made further adjustments and a year-end accrual. However, our further review again identified errors. To correct the errors, the following adjustments would be needed:

Adjustments Needed	0291	0292	0293	0294
Salaries & Wages	(3,000)	(9,254)	3,462	3,288

We found no exceptions with Fringe Benefits reporting. Actual costs incurred are reported and allocated based on staff allocations. However, due to the further Salaries & Wages errors noted above, the following Fringe Benefits adjustments would be needed to correct the Fringe Benefit reporting (which simply represent 40% of the Salaries & Wages adjustments):

Adjustments Needed	0291	0292	0293	0294
Fringe Benefits	(1,200)	(3,702)	1,385	1,315

Travel, Supplies & Materials, Contractual, Other

Of the 44 FSRs (*4 months not reported for one program*), 32 (73%) had errors with respect to reported expenses other than salaries, fringes and fees. The following types of errors were noted:

- Items charged to an LMCH cost center, but should not be an LMCH cost center.
- Items charged to the wrong LMCH cost center.
- Unallowed items, such as refreshments, gift cards, photography and tents charged.
- Accruals not included on 9/30/2017 FSRs. Adjustments trickled in from 42-119 days AFTER the 10-day FSR due date. Adjustments were significant as they represented 8% to 23% of direct expenditures of each award.

In our testing, we found that SEMHA's expense reporting agreed with the approved instructions (Check Request Form) provided by the Health Department to SEMHA. Accordingly, the misreporting appears to have been caused by misinformation provided by the Health Department to SEMHA. Furthermore, controls did not exist at the Health Department to detect the misreporting. Instead, the misreporting was detected by MDHHS's monitoring during the contract year. Some FSR corrections identified by MDHHS's Program Office were made throughout the year, but many remained as of the final FSR report. The following table summarizes the additional adjustments that would be needed to correct the misreporting:

Adjustments Needed	0291	0292	0293	0294
Travel	411	(1,089)	(411)	215
Supplies			(500)	
Contractual		2,837	(4,501)	
Other	(835)		(812)	

During our audit, we noted that the Health Department determines budgeted program FTE percentages for each employee working on multiple programs. These percentages are then used by SEMHA throughout the fiscal year to allocate salaries and wages for each employee. Compensation can be allocated to benefitting programs using a predetermined budgeted percentage for interim purposes, but 2 CFR 200 requires an adjustment to actual. During our review of employee time records, we noted that time sheets do not reflect the actual work performed by the employee when working on multiple programs. Rather, time sheets state the total hours worked during that pay period and are simply allocated to benefitting programs based on the predetermined budgeted percentage. Since time records do not show actual activity of employees, the Health Department is unable to properly conduct an analysis of actual activity to determine if any adjustments are necessary.

Recommendation

We recommend that the Health Department implement sufficient procedures and controls to ensure salaries and wages are properly allocated to benefitting programs based on actual activity to ensure compliance with Federal regulations.

Finding

3. Inaccurate and Incomplete Check Request and Requisition and Approval Forms

The Health Department did not completely and accurately complete the SEMHA Check Request Forms and Requisition and Approval Form for Expenditures.

Title 2 CFR 200.303 requires the Health Department to establish and maintain effective internal control over the Federal award that provides reasonable assurance that the Health Department is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. The Health Department's internal control over financial reporting includes the Check Requests Policies and Procedures; and established forms (SEMHA Check Request Form and Requisition and Approval Form for Expenditures) that document cost centers, budget lines, explanations, allowability and approvals.

We selected 22 expenditures for which the SEMHA Check Request Form and Requisition and Approval Form for Expenditures were used, and tested the forms for proper completion and approval. While all of these were approved by the Program Manager, Finance Manager, and Deputy Director, multiple exceptions were noted as follows:

- 17 (77%) were charged to the wrong cost center (the wrong cost center was completed on the Check Request Form 14 times; and the correct cost center was completed on the Check Request Form 3 times, but was changed to the incorrect cost center 2 times by the Operations Administrator, and charged to the incorrect cost center by SEMHA 1 time).

During our audit, we noted that only one of the quarterly FSRs for the four programs was submitted on time (this program had zero expenditures at that time). Of the 16 FSRs (quarterly and final), 15 (94%) were submitted late, and the lateness ranged from 32 to 128 days late. Monthly FSR filings from SEMHA were delinquent 20% of the time, by exceeding the 10-day timeframe by 2 to 16 days in 9 of the 44 FSRs filed. However, quarter-end reporting by SEMHA was generally timely with only 1 FSR past the 10-day due date by 16 days. Accordingly, SEMHA FSRs were generally provided in sufficient time to meet MDHHS filing deadlines. Multiple corrections and year-end adjustments appeared to be the primary reasons for the significant lateness.

Recommendation

We recommend that the Health Department implement sufficient procedures and controls to ensure accurate and timely FSR filings in accordance with contract provisions.

COMPLIANCE MONITORING

Objective 2: To assess the Health Department's effectiveness in complying with monitoring requirements with respect to timely and accurate fiscal reporting.

Conclusion: The Health Department was not effective in complying with monitoring requirements related to timely and accurate fiscal reporting. We found exceptions relating to insufficient monitoring (Finding 5), and lack of timely corrective action (Finding 6).

Finding
5. Insufficient Monitoring

The Health Department did not adequately monitor their compliance with the terms and conditions of the Federal award related to timely and accurate fiscal reporting.

Title 2 CFR 200.303 requires the Health Department to:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity [Health Department] is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)...

The 34 outstanding corrections had all been previously communicated to the Health Department as follows, but remained outstanding as of the February 2018 FSR filings:

Month Communicated	Number of Items to be Corrected
February 2017	2
May 2017	13
August 2017	1
October 2017	15
December 2017	3

Health Department personnel provided us with a Financial Status Report Review, Amendment and Submission Form; and Routing Form that they implemented subsequent to our review period. These document FSR approvals, required adjustments, adjustment approvals, and adjusted FSR approvals. These should help ensure required FSR adjustments are completed.

Recommendation

We recommend that the Health Department implement sufficient procedures and controls to ensure that prompt corrective action is taken when instances of non-compliance are identified.

INDIRECT COST REPORTING

Objective 3: To assess the Health Department's accuracy in reporting indirect costs in accordance with Federal cost principles.

Conclusion: The Health Department did not accurately report indirect costs in accordance with Federal cost principles. We noted non-compliant indirect cost allocations (Finding 7).

Finding

7. Non-Compliant Indirect Cost Allocations

The Health Department did not properly allocate indirect costs in accordance with Federal regulations.

The MDHHS Grant Agreement, Part II, Section IV. K. Indirect Costs and Cost Allocations/Distribution Plans states, "...4. There must be a documented, well-defined rationale and audit trail for any cost distribution or allocation based upon Title 2 CFR, Part 200 Cost Principles and subject to Department review."

During our audit, we identified the following three categories (cost pools) of indirect cost for which the Health Department receives benefit from:

A.) **The Citywide Central Services Costs**
These costs are for services provided on a centralized basis for the city's operating agencies for things such as financial operations, human resources, auditing, general services, contracting and procurement, legal, and executive costs.

B.) **Detroit Health Department (DHD) Administrative Shared Costs**
These costs are DHD administrative costs related to staff hired through SEMHA and invoices paid by SEMHA for things such as administrative assistance, budget development and management, contract development and monitoring, data design, facilities, human resources, logistics, quality improvement, strategic leadership communication, community relations, and social media.

C.) **DHD Administrative In-House Costs**
These costs are DHD administrative costs related to personnel working at DHD, such as the Health Officer, deputies, division managers, program managers, and their associated expenditures.

During our review of reported indirect costs, we noted various exceptions related to the above categories of indirect cost as noted below:

Citywide Central Services Costs

1.) The Health Department used a predetermined rate of 3% of total direct program expenditures and the allocable share of the DHD Administrative Shared Costs to report costs related to the Citywide Central Services Costs. However, there was no indirect cost rate proposal, negotiation, nor formal agreement related to this indirect cost rate as required by Appendix VII, Section F. 3. of 2 CFR 200.

2.) The Health Department used an incorrect amount from the June 30, 2015 Citywide Central Services Cost Allocation Plan for budgeting purposes, using an amount of $2,019,200 from one line below the Health Department line that contained an amount of $651,311. While the rate was capped at 3%, using the correct amount of $651,311 would have resulted in a lower rate of 2.62%.

3.) The Health Department did not allocate Citywide Central Services Costs to all benefitting programs.

PROCUREMENT STANDARDS

Objective 4: To assess the City of Detroit's effectiveness in complying with applicable procurement standards related to the Professional Services Contract with the Southeastern Michigan Health Association.

Conclusion: The City of Detroit generally complied with applicable procurement standards. However, we identified one exception regarding a lack of cost analysis for the SEMHA contract (Finding 8).

Finding

8. Lack of Cost Analysis for SEMHA Contract

The City of Detroit's Office of Contracting and Procurement (OCP) did not perform a cost or price analysis prior to executing its Health Department's contract with SEMHA.

Title 2 CFR 200.323 Contract cost and price states, "(a) The non-Federal entity must perform a cost or price analysis in connection with every procurement action in excess of the Simplified Acquisition Threshold including contract modifications. The method and degree of analysis is dependent on the facts surrounding the particular procurement situation, but as a starting point, the non-Federal entity must make independent estimates before receiving bids or proposals." Also, Title 2 CFR 200.318(i) requires the non-Federal entity to maintain records sufficient to detail the history of procurement, and the records must include the basis for the contract price.

During our audit, we noted that the OCP never performed a cost or price analysis in connection with the fiduciary and grants administration services procurement action. We also noted the OCP's Request for Proposal (RFP) required a cost proposal to be attached to the agency's bid proposal, which included a schedule of fees or hourly rates broken out for each type of staff member that will work on the project. This schedule of fees was never provided and instead, SEMHA bid a firm cost proposal of a 5% fee for all programs listed on the RFP and a 2.75% fee for the Ryan White program. By accepting the flat 5% and 2.75% fees with no cost analysis, the OCP was not in compliance with its own RFP or Federal regulations.

Recommendation

We recommend that the OCP implement sufficient controls and procedures to conduct a cost analysis prior to executing or renewing any contracts and maintain records that include the basis for contract prices to ensure compliance with Federal regulations.

City of Detroit
Local Maternal and Child Health Programs
Adjustment Schedule
October 1, 2016 - September 30, 2017

293 - PH FUNCTIONS / INFRASTRUCTURE	REPORTED	ADJUSTMENTS	CORRECT TOTAL	Budget	Under / (Over) Budget
Salaries & Wages	$87,638	$3,462	$91,100		
Fringe Benefits	49,253	1,385	50,638		
Travel	7,646	(411)	7,235		
Supplies & Materials	11,318	(500)	10,818		
Contractual	79,468	(4,501)	74,967		
Other	110,755	(812)	109,943		
Total Direct	346,078	(1,377)	344,701		
Negotiated 5% Rate	17,181	54	17,235		
Contractual	363,259	(1,323)	361,936	432,482	70,546
Indirect Costs	11,855		11,855	14,471	2,616
Other Costs Distributions	31,917		31,917	35,397	3,480
Total Expenditures	$407,031	($1,323)	$405,708	$482,350	$76,642

294 - DIRECT SERVICES CHILDREN	REPORTED	ADJUSTMENTS	CORRECT TOTAL	Budget	Under / (Over) Budget
Salaries & Wages	$72,296	$3,288	$75,584		
Fringe Benefits	35,132	1,315	36,447		
Travel	2,245	215	2,460		
Supplies & Materials	2,857	0	2,857		
Contractual	5,000	0	5,000		
Other	0	0	0		
Total Direct	117,530	4,818	122,348		
Negotiated 5% Rate	5,877	241	6,117		
Contractual	123,407	5,059	128,465	131,958	3,493
Indirect Costs	4,415		4,415	4,896	481
Other Costs Distributions	23,758		23,758	26,349	2,591
Total Expenditures	$151,580	$5,059	$156,638	$163,203	$6,565

payables are liquidated within 75 days after the agreement fiscal year-end as required by the MDHHS contract.

Person Responsible for Implementation: Finance Manager

Anticipated Completion Date: November 7, 2017

MDHHS Response: None

Corrective Action Plan

Finding Number: 3

Page Reference: 6

Finding: Inaccurate and Incomplete Check Request and Requisition and Approval Forms

The Health Department did not completely and accurately complete the SEMHA Check Request Forms and Requisition and Approval Form for Expenditures.

Recommendation: Implement sufficient procedures and controls to ensure that SEMHA Check Request Forms and Requisition and Approval Form for Expenditures are accurate and complete, including only allowed costs that are designated to the appropriate cost centers, to help ensure accurate FSR reporting.

Comments: DHD agrees with the finding and recommendation.

Corrective Action: DHD implemented checks and balances by adding additional reviewers to ensure expenses are charged to the appropriate cost centers and line items. All check requests not submitted accurately are returned to the LMCH Program Director for corrections. Additionally, the Check Requests Policy and Procedures has been revised and will be distributed to staff.

Person Responsible for Implementation: Finance Manager and LMCH Program Director

Anticipated Completion Date: October 1, 2017

MDHHS Response: None

Corrective Action Plan

Finding Number: 5

Page Reference: 8

Finding: **Insufficient Monitoring**

The Health Department did not adequately monitor their compliance with the terms and conditions of the Federal award related to timely and accurate fiscal reporting.

Recommendation: Implement required monitoring activities over fiscal reporting that include evaluations to ascertain whether the components of internal control are present and functioning, and communications of deficiencies in a timely manner to those parties responsible for taking corrective action.

Comments: DHD agrees with the finding and recommendation.

Corrective Action: A member of the DHD Senior Leadership team, the finance team and Program Director meet monthly to review each line item on the monthly FSRs. Additionally, the LMCH Program Director and a member of the finance team meet monthly with the State program managers to review and approve all FSRs. Beginning in FYE 2019, DHD will conduct periodic internal audits to assess the effectiveness of established internal controls.

Person Responsible for Implementation: Finance Manager

Anticipated Completion Date: October 1, 2018

MDHHS Response: None

Corrective Action Plan

Finding Number: 7

Page Reference: 10

Finding: Non-Compliant Indirect Cost Allocations

The Health Department did not properly allocate indirect costs in accordance with Federal regulations.

Recommendation: Implement sufficient controls and procedures to ensure that all indirect costs are allocated based on actual and allowable expenditures, and in accordance with relative benefits received to ensure compliance with Federal regulations.

Comments: DHD agrees with the finding and recommendation.

Corrective Action: DHD will implement procedures to ensure indirect costs are allocated in accordance with 2 CFR 200 which will ensure that all indirect costs are allocated based on actual allowable expenditures, and will reconcile any discrepancies at the end of the program year relative to benefits received.

Person Responsible for Implementation: Finance Manager

Anticipated Completion Date: October 1, 2018

MDHHS Response: None

Anticipated Completion Date: October 1, 2018

MDHHS Response: None

3. **Insufficient Controls Over Financial Management System**

The Health Department did not have sufficient controls over its financial management system to ensure all administrative expenditures were accurately recorded in the financial records.

Title 2 CFR 200.62 states, "Internal control over compliance requirements for Federal awards means a process implemented by a non-Federal entity designed to provide reasonable assurance regarding the achievement of the following objectives for Federal Awards:

(a) Transactions are properly recorded and accounted for, in order to:
    (1) Permit the preparation of reliable financial statements and Federal reports;
    (2) Maintain accountability over assets; and
    (3) Demonstrate compliance with Federal statutes, regulations and terms and conditions of the Federal award."

During our review of a sample of indirect expenditures, we noted multiple expenditures that were recorded to improper general ledger accounts such as Verizon wireless bills recorded as advertising expenses, and laptop purchases recorded as building acquisitions. Additionally, an improper entry to vehicle acquisitions was later reversed, but improperly reversed from buildings acquisitions. We recommend that the Health Department implement sufficient controls over its financial management system to ensure compliance with Federal regulations.

Management Response: DHD implemented controls in FYE 2018 to assure that all allowable and budgeted items are charged and recorded properly to budget lines. This includes requiring and verifying appropriate indirect/administrative expenses and ensuring that only budgeted indirect/administrative expenditures are charged. DHD Senior Leadership and the Finance team meet to review those indirect/administrative charges monthly and make adjustments prior to the issuance of any final FSRs.